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no.15

Selected

**PUBLIC HOSPITAL
and MEDICAL PLANS**
in Canada

RESEARCH DIVISION

Social Security Series

No. 15

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Ottawa

July 1955

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SELECTED PUBLIC HOSPITAL AND MEDICAL CARE PLANS
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FOREWORD

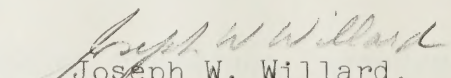
This bulletin is the first published by the Research Division of the Department of National Health and Welfare dealing with public health care plans in Canada. It describes the experience of the public hospital care plans in the Provinces of British Columbia, Alberta, and Saskatchewan, the public hospital and medical care plan in the cottage hospital districts of Newfoundland, and the medical care plans operating in Swift Current, Saskatchewan, and in certain other centers of Saskatchewan and Manitoba. These plans, operating under a variety of administrative arrangements, have been devised to meet the widely varying geographic, economic and social conditions of their areas.

Earlier bulletins in the Social Security Series (Memoranda Numbers 8 to 11) described the public programs in New Zealand, Denmark, Sweden, and Great Britain. Two publications in the General Series have described the operations of Canadian voluntary health care insurance plans. "Voluntary Medical Care Insurance: a study of non-profit plans in Canada" (Memorandum Number 4) analyzes, in some detail, fourteen non-profit medical care insurance plans, while "Voluntary Medical and Hospital Insurance in Canada" (Memorandum Number 9) describes in more general terms the operations of private insurance companies as well as non-profit organizations in insuring against the costs of both medical and hospital care.

The material contained in this publication has been prepared in co-operation with various provincial health

authorities and the generous assistance of the following officials is most gratefully acknowledged: Mr. D.M. Cox, Commissioner, and Mr. L.F. Detwiller, Assistant Commissioner, of the British Columbia Hospital Insurance Service, and Dr. G.F. Amyot, Deputy Minister of Health of British Columbia; Dr. A. Somerville, Deputy Minister of Public Health and Dr. M.G. McCallum, Director, Hospital and Medical Services Division of the Province of Alberta; Dr. F.B. Roth, Deputy Minister of Public Health of Saskatchewan, Dr. M.S. Acker, Director, Research and Statistics, Dr. V.L. Matthews, Regional Medical Health Officer, Swift Current Health Region, and Mr. S. Robertson, Secretary-Treasurer of the Swift Current Health Region; Dr. M.R. Elliott, Deputy Minister of Health and Dr. I.M. Cleghorn, Director, Extension Health Services of Manitoba; and Dr. L. Miller, Deputy Minister and Dr. J.M. McGrath, Assistant Deputy Minister of the Department of Health of Newfoundland. Without the extensive statistical data provided and the many helpful comments and suggestions offered by these officials, this study would not have been possible. This Division, however, takes full responsibility for the statistical and other material contained herein.

This bulletin was prepared in the Health Care Studies Section by John E. Sparks and John E. Osborne, under the supervision of C. Lloyd Francis.


Joseph W. Willard,
Director, Research & Statistics Division.

Sept. 1955.

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Chapter I

INTRODUCTION

The public hospital and medical care programs selected for analysis in this bulletin covered about 2.8 million Canadians in 1953, or 19 per cent of the total population. They reflect variations in administrative arrangements, benefit provisions, and methods of payment for services which have been worked out in different parts of Canada with widely varying economic, geographic and social conditions. All of the programs selected, however, cover the residents of an area without employing tests of income as a basis for eligibility, or making exclusions based on such factors as age, employment or occupation.

Other public programs designed for particular groups of people have not been included in this study. For example, five provinces have formal programs to provide medical and in some cases hospital care to about 300,000 public assistance recipients. The federal government also provides medical and hospital care for some 160,000 Indians and Eskimos, and over 115,000 members of the Armed Forces. In addition, about 20,000 Canadian mariners are insured for hospital and medical services under the Sick Mariners Program. Some 155,000 war pensioners are eligible for medical care for service-connected illnesses, and 35,000 recipients of War Veterans Allowances, and their dependents, for full hospital and medical care. More than 500,000 other veterans, as well as pensioners for non-service-connected disabilities, may receive treatment either free or on a repayment basis depending on their income status. None of these programs is discussed in this bulletin.

Four provinces have introduced compulsory hospital care programs providing a varying range of hospital care benefits to all or a portion of their residents. Residents of British Columbia are compulsorily covered for complete in-patient standard ward hospital care under the British Columbia Hospital Insurance Service. At present, the scheme is almost entirely financed from the general revenues of the province, with small municipal per diem grants, and charges to patients of \$1 per day. All ratepayers in Alberta's Municipal Hospital Districts are automatically covered under that province's Municipal Hospital Plan for room and board at \$1 per day, and in many districts for auxiliary services at no more than \$1 per day, the remainder of the cost being shared about equally by the municipality and the province; resident non-ratepayers may voluntarily enroll for the same benefits by purchasing a hospital care contract from the municipality for about \$10 per family per year. An estimated three-quarters of Alberta's population were covered under this scheme in 1954.

Saskatchewan's population is enrolled for complete in-patient standard ward hospital care under the Saskatchewan Hospital Services Plan, which is financed about equally from general revenues and personal premiums ranging between \$15 and \$40 annually. These three programs are examined in Chapter II.

More than one-third of the population of Newfoundland are covered under that province's Cottage Hospital Program which provides complete hospital and medical care to families

in the "outport" areas. About two-thirds of the revenues of the program are provided by the province; the remainder is obtained from compulsory premiums, usually \$15 per family annually. The Newfoundland program is the subject of Chapter III.

As of June, 1955, only three provinces had introduced compulsory medical care programs; these were limited to the residents of particular sections of each province, and covered about 400,000 persons. As previously mentioned, over one-third of Newfoundland's population is entitled to complete medical care at home or in hospital under the Cottage Hospital Program. Manitoba and Saskatchewan both have Municipal Doctor programs, covering in 1955 about 30,000 people in Manitoba and 167,000 in Saskatchewan, under which certain municipalities have contracted with physicians to provide their residents with medical care. These schemes may provide a complete range of medical care, or only a limited general practitioner service, and may be financed out of property taxes, personal taxes, or a combination of both. And finally, a medical-dental care program is available to all 48,000 residents of Health Region No. 1 in the Swift Current area of Saskatchewan, whereby a complete range of medical care services in the home, office and hospital, surgical and obstetrical services and a children's dental care program, are provided on payment of a compulsory personal tax of \$18 annually for single persons, \$44 for families of four or more, and a property tax of about 2 mills.

These two programs together cover about 25 per cent of Saskatchewan's population. The Swift Current program and the Municipal Doctor schemes are analyzed in Chapter IV of this bulletin.

In order to indicate the extent to which these public plans have developed in relation to the populations of the provinces in which they operate, and of the country as a whole, the following table is presented, which shows that in 1953 about 19 per cent of the Canadian population were covered for hospital care under public plans, and about 2.7 per cent for medical care.

<u>Province</u>	<u>Hospital Care Plans</u>		<u>Medical Care Plans</u>	
	<u>Numbers Covered</u>	<u>Per Cent of Population</u>	<u>Numbers Covered</u>	<u>Per Cent of Population</u>
Newfoundland	140,000	36.5	140,000	36.5
Manitoba	-	-	40,000	4.9
Saskatchewan	804,000	93.4	220,000	25.6
Alberta	750,000(a)	75.0	-	-
British Columbia	1,107,000(a)	90.0	-	-
CANADA	2,801,000	19.0	400,000	2.7
(a) Estimated				

These figures should also be related to the expenditures of the public plans on hospital and medical care in order to place them in their proper perspective in relation to total payments to public and private hospitals and to physicians in 1953. The four public hospital plans, which covered 19 per cent of the total population in 1953, paid out almost \$49 million in hospital benefits in that year, or about 19 per cent of the total payments of \$263 million to

public and private hospitals. With only 2.6 per cent of the Canadian population covered under these public medical care programs in 1953, the payments to physicians by these programs in that year represented a negligible proportion as would be expected of the total receipts of physicians. It is estimated that these programs paid about \$1,750,000 to physicians in 1953, or just over 1 per cent of the estimated total payments of \$170 million to physicians in independent practice.

	Public and Private Hospitals		Physicians	
	Total Payments	Percentage Distribution	Total Payments	Percentage Distribution
	\$ million		\$ million	
By patients directly	94.8	36.0	104.1	61.0
On behalf of patients by:				
Public Plans	48.5	19.0	1.8	1.0
Voluntary Plans	62.7	24.0	42.4	25.0
Other Public Programs	17.0	6.0	10.7	6.0
Workmen's Compensation ^(a)	10.4	4.0	8.5	5.0
Other	-	-	2.5	2.0
Public Grants, Donations	29.6	11.0	-	-
Total Payments	263.0	100.0	170.0	100.0

(a) Estimated

Source: Research Division, Department of National Health and Welfare, Health Care in Canada; Expenditures and Sources of Revenue, 1953, General Series Memo No. 12, (D. N. H. & W.: Ottawa, 1955), Tables 3 and 4.

CHAPTER II

PUBLIC HOSPITAL CARE PLANS

BRITISH COLUMBIA HOSPITAL INSURANCE SERVICE

Since January 1, 1949, the province of British Columbia has operated a comprehensive public hospital insurance service. Benefits include public-ward care and basic auxiliary services and are presently financed by grants from the Consolidated Revenue Fund⁽¹⁾ and statutory provincial and municipal hospital per diem grants. In addition, special appropriations are made from general provincial revenues to finance grants-in-aid made by the province towards hospital construction.⁽²⁾ In the first six years of operation, the plan is estimated to have paid over \$125 million on behalf of over one million patients.

COVERAGE

Hospital insurance in British Columbia, as in Saskatchewan, is based on the principle of universal coverage. There are, of course, certain exclusions dealing with persons covered under other programs, as well as a residence qualification. Twelve months' continuous residence prior to

-
- (1) These appropriations are charged against receipts from the Social Service Tax, a five per cent provincial retail sales tax. Until April 1, 1954, a personal premium or tax was collected. The provincial sales tax was increased from three to five per cent, on that date, and personal premiums discontinued. Each patient is required to pay one dollar per day "co-insurance" to the hospital as his direct share of the cost of treatment.
- (2) The province will contribute one-half the cost of approved construction (including land and fixed equipment) and one-third the cost of major alterations or improvements and movable equipment; the remainder is financed by the community and grants from other sources including the federal government.

application for admission to hospital must be established.⁽¹⁾
During the twelve-month qualifying period, individuals may be temporarily absent for a period of three months.

A person may lose his status as a "resident" if he leaves British Columbia and is absent for more than one year. Upon his return, he is considered as a "new resident", and must wait one year from the date of arrival before becoming eligible for benefits. However, if his dependents remain within the province during his absence, he may retain such status indefinitely, and may obtain immediate coverage upon his return to the provinces, even though he may have been absent for more than one year.⁽²⁾

Patients in tuberculosis sanatoria and mental institutions (who usually receive care at public expense), and inmates of jails and the penitentiary are excluded from benefits under the Hospital Insurance Act during the time spent in such institutions.

Also excluded is any person entitled to receive hospital care or treatment:

- (a) From the Government of Canada by reason of the fact that he is a member or former member of Her Majesty's Armed Forces; or
- (b) From the Government of Canada or any other government for any other reason; or

(1) The spouse and dependent children arriving in the province after the head of the family take his residence status.

(2) For out-of-province benefits, see p. 5.

- (c) Under the provisions of the "Workmen's Compensation Act", the "Canada Shipping Act", or any other Act, or by any other means, and without his being required to pay any sum to become so entitled.

Dependents of such persons are eligible, however, if they meet the residence requirements. Dependents are defined as the spouse of the head of the family or a child under 21 years who is mainly supported by the head of the family.

Prior to the abolition of personal premiums in 1954, special arrangements were made to include the recipients of various forms of public assistance. In the period before the new old age programs were introduced in January 1952, the Province, like Saskatchewan, paid hospital premiums on behalf of old age and blind pensioners, mothers' and social allowance recipients, and the dependents of all categories. Beginning January 1952, recipients of the new Old Age Assistance scheme were made eligible for benefits. Also, with the introduction of the universal federal old age pension at that time, those formerly in receipt of means test pensions continued to be covered, with hospital benefits being extended to new pensioners meeting the requirements of a means test.

From April 1952 to April 1954, however, the Department of Health and Welfare (Social Welfare Branch), rather than pay premiums on behalf of the above-mentioned categories,

assumed the actual costs of care at the time of their hospitalization. Since April 1954, the public assistance group have not been distinguished from other beneficiaries.

Prior to April 1, 1954, the definition of a dependent was very broad, and included persons other than members of the immediate family.⁽¹⁾ However, since residency is now the determining factor in obtaining benefits, coverage is almost universal with the exception of a very small group of transients and the few exclusions previously described. Therefore, it has not been necessary to continue the previous regulations dealing with dependents, since most of the persons concerned may now obtain benefits in their own right as they qualify as residents under the new policies. If they do not qualify as residents, they must undergo the waiting period of one year.

(1) Prior to April 1, 1954, a "dependent" was defined as:

- (a) The spouse of the head of a family; or (b) An unmarried person under 19 years of age who is designated as dependent by the Commissioner; or (c) An unmarried person under 19 years of age who is mainly supported by the head of a family and over whom, in law or in fact, the head of a family has complete custody and control, whether exercised jointly with another person or not; or (d) An unmarried son or daughter, brother or sister, over 18 years of age and under 21 years of age who is mainly supported by the head of a family and a student at a secondary school, university, or other educational institution recognized by the Commissioner; or (e) A son or daughter, brother or sister, including a son-in-law, daughter-in-law, brother-in-law, or sister-in-law, over 18 years of age who is financially dependent upon the head of a family by reason of physical or mental infirmity; or (f) A parent, parent-in-law, grandparent, or grandparent-in-law who is financially dependent on the head of a family.

BENEFITS

A resident who is admitted as an in-patient upon the recommendation of a physician, is eligible to receive the following services, if required, and if provided by the hospital:

Public-ward accommodation (including general nursing care);
The use of operating and case-room facilities, equipment, and anaesthetic supplies;
Approved drugs and biologicals;
Surgical dressings and casts;
X-ray, laboratory, diagnostic, and physiotherapy services; and all other services rendered by hospital employees.

The above benefits are restricted to patients with acute conditions, although those suffering from the acute stage of chronic conditions may receive service. An opinion by the patient's physician, acceptable to the Administration, as to whether continued acute treatment is a medical necessity, is the criterion applied to the duration of treatment to be provided, rather than a definite time limit.

Payments for hospital care of \$3.50 per day for newborns and \$8.00 per day for adults and children, usually up to a maximum of 30 days, with extension upon approval of the Minister, are paid to beneficiaries (or on their behalf) who incur hospitalization in approved hospitals outside of British Columbia during the first three months after leaving the Province.

Benefits do not include, however, out-patient care, semi-private or private accommodation, the services of physicians or special nurses not employed by the hospital, or the provision of a few drug products.

Short-stay cases, that is, those requiring either out-patient emergency care within 24 hours following an accident, or minor surgery which cannot be performed in a doctor's office (estimated at about 63,000 patients in 1954), may also receive certain out-patient services upon payment of a \$2.00 charge. Other types of out-patient services, such as diagnostic procedures, are not included as benefits. Short-stay benefits do not apply outside the Province.

UTILIZATION

On the basis of the available data, it is difficult to indicate accurately the effect of the operation of the insurance program on hospital utilization. The material given below, which relates to the use of public general hospitals (only) by all patients in the Province, including both B.C.H.I.S. beneficiaries and those persons who were exempt or not eligible for benefits by reason of premium default or lack of residency qualifications, does indicate, however, the general utilization picture in the pre- and post-insurance periods.

As was the case in most other provinces, British Columbia had experienced, prior to 1949, long-term trends

towards higher separation (admission) rates and lower average lengths of stay per case. As will be noted in Table 1, hospital separation rates continued to rise over the first five years of the insurance program, but in its first year, the average length of stay also rose. When co-insurance payments were introduced in 1951, average length of stay per case reached a low of ten days (9.96), but by 1954 it had climbed to an estimated 10.5 days. Days of care per 1,000 persons (excluding newborns) for the total population of the province have been steadily rising, to a rate of 1,621 days in 1953 and to an estimated rate of 1,683 days in 1954. If B.C.H.I.S. beneficiaries only are counted, and cases covered by Workmen's Compensation and certain other ineligible persons are excluded, the rate of days in public general and certain special and private hospitals has been estimated at 1,786 days per 1,000 covered persons for 1954.

Table 1. Public General Hospital Utilization,
1946-1954
(Excluding Newborns)

Year	Separation Rate Per 1000 Popu- lation(a)	Average Length of Stay per Case(b)	Hospital Days Per 1,000 Population
1946	131.1	10.7	1406.8
1947	138.1	10.6	1471.3
1948	140.8	9.9	1389.1
1949	143.3	10.2	1456.6
1950	147.1	10.2	1494.9
1951	150.3	10.0	1497.0
1952	154.8	10.4(c)	1602.8(c)
1953	160.5	10.1	1621.4
1954	160.7(d)	10.5(d)	1683.3(d)

Footnotes to Table 1.

- (a) Based on discharges and deaths of all public general hospital patients, both insured and uninsured.
- (b) Based on reported days of separations (discharges and deaths), 1946-1951; 1952 based on days hospitalization in the year; 1953, estimated days on separation; 1954, reported days on separations.
- (c) Estimate, adjusted to exclude about 225 chronic beds in general hospitals. The unadjusted average stay was 10.8 days, and the rate of hospital days, 1673 days per 1000 population.
- (d) Estimate, based on D.B.S. preliminary unpublished data, adjusted to exclude an 81 chronic bed unit in a general hospital. The unadjusted average stay was 10.6 days, and the rate of hospital days, 1707 days per 1000 population.

Source: Adapted from data from the Bureau of Statistics Annual Report of Hospitals, 1948-1952, Hospital Statistics 1953, and preliminary unpublished data, 1954.

FINANCES

REVENUES

Payments to hospitals for services to eligible persons, as well as the cost of administering the program, are met from the Hospital Insurance Fund. The Minister of Finance from time to time out of the Consolidated Revenue Fund pays to the Hospital Insurance Fund such sums of money as are required to carry out the provisions of the Hospital Insurance Act. The Estimates of the province show that these appropriations are charged against receipts from the Social Services Tax, a five per cent provincial retail sales tax. The Insurance Fund continues to receive the traditional statutory municipal and provincial grants of 70 cents per diem for each resident patient.

THE HISTORY OF PREMIUM COLLECTIONS⁽¹⁾

Prior to the changes of April, 1954, the following compulsory personal premium rates were in force:

	<u>1949</u>	<u>1950</u>	<u>1951</u>	<u>1952</u>	<u>1953</u>
Single persons	\$ 15	21	30	27	27
Head of family with one dependent	24	33	42	39	39
Head of family with two or more dependents	30				
Co-insurance	-	-	$\left\{ \begin{array}{l} \$2.00 \text{ to} \\ \$3.50 \text{ per day} \\ \text{up to 10} \quad \$1.00 \text{ per} \\ \text{days maxi-} \quad \text{day} \\ \text{mum per yr.} \quad \text{No maximum} \end{array} \right.$		

Co-insurance charges, payable by the patient, and ranging from \$2.00 to \$3.50 per day,⁽²⁾ with a maximum of 10 days' payment per year for each individual or family group, were introduced April 1, 1951. In August 1952 these were amended to \$1.00 for each day of hospitalization, with no maximum, and have since been retained at this rate.⁽³⁾ While it is difficult to determine the effect which these charges may have had on the length of stay in hospital, they may have been responsible, to some degree, for the decrease in the length of stay in 1951,⁽⁴⁾ when the larger co-insurance charges were in effect.

(1) Since the changes of April 1, 1954, this section is of historical interest only.

(2) Depending on the approved daily charge made by the hospital to B.C.H.I.S. for the patient's care.

(3) The provincial government makes these payments on behalf of public assistance recipients.

(4) The average length of stay per B.C.H.I.S. case (excluding newborns) in the public hospitals of the province was as follows: 1949-10.21 days; 1950-10.19; 1951-9.77; 1952-10.17; 1953-10.13; 1954-10.31.

After experimentation with different payment periods for persons making premium payments through payroll deduction or by direct payment through district offices, the plan, in May, 1953, standardized its collection procedures. All wage earners on payroll deduction (approximately 230,000 by the end of 1953) made monthly advance payments, covering the month following payment. Persons not on payroll (i.e. on direct payment) were billed twice yearly, and in effect pre-paid six months in advance.

In order to extend coverage to persons temporarily unable to make premium payments and to meet British Columbia's high labour turnover, the Province in July, 1953, developed a special method of building up "insured benefits." A maximum of three months of paid-up insurance was to have been obtained at the end of eighteen months of payment (i.e. one month insurance for every six months of payment). This was not to be considered an exemption from premium payment for the "insured benefit" period, since coverage would be provided only if the person was unable to pay his premium for financial reasons. If a premium were paid for the six-month period in question, then the "insured benefit" period carried forward until it was required. In addition, provision was made for those temporarily unemployed for any reason (including sickness) to suspend their arrears for a maximum of one month; upon return to employment, payroll deduction was made for two months (i.e. one month in arrears and one

month prepayment). If persons on direct payment (who were billed twice a year) did not pay on the due date, or within the seven days of grace following, they were required to wait an additional fourteen days after payment to regain eligibility status. If they had not paid a premium for the previous six months, they were obliged to wait one month before achieving eligibility for benefits. Such waiting periods did not apply, of course, where the beneficiary was receiving insurance coverage under the "insured benefit" periods mentioned above. It is important to note that coverage was sold in six-month periods and arrears were not carried forward from one period to another. These premium payment requirements terminated when the new method of financing the program was introduced on April 1st, 1954.

EXPENDITURES

As previously mentioned, payments to hospitals for services to eligible persons as well as the costs of administering the program are met from the Hospital Insurance Fund. Table II has been designed to show, on a fiscal year basis, the receipts and disbursements of the Fund. From this Table it is possible to calculate the percentages which personal premiums revenues, per diem grants, and provincial payments for public assistance recipients, and other sources of revenue bore respectively to total expenditures. This analysis, on a year-by-year basis, is described below.

From 1949-50 through 1953-54, a five year period, personal premiums of \$66.2 million met about 63 per cent of total expenditures amounting to \$105.6 million. Consolidated revenue fund payments of \$35.1 million represented 33 per cent.⁽¹⁾ These proportions can be compared with 45 and 55 per cent respectively over the first five years of the Saskatchewan scheme. Strictly speaking, provincial general revenue payments to cover subsidies and deficit grants (\$17.1 million) met only about 16 per cent of total expenditures over the five years, but an additional 10 per cent (\$10.6 million) was expended by the province on behalf of public assistance cases, and about 7 per cent (\$7.3 million) in the form of continued provincial statutory per diem grants.

In the first full fiscal year, 1949-50, personal premiums represented just over 50 per cent of the sums paid for the hospitalization of beneficiaries and for administering the program. Municipal and provincial per diem grants, a long standing form of subsidy payments to hospitals, met about 10 per cent of such expenditures, and premium payments by the province on behalf of public assistance cases about 4 per cent, leaving an operating deficit representing 36 per cent of total expenditures.

In 1950-51 with an increase in premium receipts (meeting 64 per cent of expenditures) and a sizeable

(1) The remaining 4 per cent was represented by statutory municipal per diem grants of \$4.3 million.

reduction in payments to hospitals, the amount required from provincial sources met about 32 per cent of expenditures. Such payments, however, included statutory per diem grants of 8 per cent and premium payments for public assistance cases representing 6 per cent. Thus the operating deficit represented only 18 per cent of expenditures as compared to 36 per cent in 1949-50.

In summary, personal premium revenues covered about 57 per cent of total expenditures in these two years, municipal grants about 3.5 per cent, and provincial subsidies, grants and premium payments on behalf of public assistance the remaining 39.5 per cent.

During the year 1950-51, there was a very considerable increase in the size of personal premium revenues (rate increases were effected July 1, 1951), which represented some 83 per cent of expenditures as against a budgeted 66 per cent. At the same time actual payments to hospitals were less, by some \$1.3 million, than what had been estimated. The hospitals, however, received co-insurance payments directly from patients amounting to about \$2 million.⁽¹⁾ Municipal per diem grants likewise exceeded estimated receipts. The result was that in 1951-52 the \$2.5 million subsidy voted to the B.C. Hospital Insurance Fund from Consolidated Revenue was not required in that year. The total amount required from

(1) Revenues from this source are not included in Table II.

provincial sources (premium payments on behalf of the public assistance group, provincial statutory per diem grants) represented only about 15 per cent of total expenditures, and the year's operations showed a surplus of \$665,000.

With a reduction in premium rates in 1952-53, there was a slight decline in personal premium revenues but a sizeable increase in payments to hospitals - nearly 30 per cent over the previous year. Thus provincial assistance was required to meet almost one-third of the total cost in that year. During 1953-54 there was a further increase of over 10 per cent in payments to hospitals, accompanied by a further reduction in premium receipts of about 6 per cent. Total provincial revenues were then required to assume 41 per cent of total expenditures, a higher level of provincial support than was required in any previous year.

With the elimination of personal premiums in April 1954, Consolidated Revenue payments to the Hospital Insurance Fund were estimated to meet all but about 3 per cent of total expenditures in 1954-55 and 1955-56; the remainder was to be derived from the municipal grants of 70 cents per patient day.

While neither British Columbia nor Saskatchewan had designed their personal premium structures so that such revenues, together with provincial and municipal per diem grants and premium payments on behalf of public assistance

recipients, would meet the full cost of their programs, British Columbia, prior to April 1954, had required proportionately greater personal premium revenues, as mentioned above. Furthermore, unlike Saskatchewan, the B.C. program operated through a Fund, which, in addition to the above revenues, received subsidies from the Consolidated Revenue Fund. As shown in Table II such subsidies were not required in certain years. The unexpended portion, however, did not revert to the treasury but was retained in the Hospital Insurance Fund which by March 31, 1954, had a cash balance of some \$6.5 million. With the change in financial policy in 1954, that portion of the Fund which represented premiums paid in advance for periods subsequent to April 1, 1954, some 60 per cent of the total, was refunded to eligible beneficiaries, and the remaining 40 per cent transferred to the Consolidated Revenue Fund.

(1) Costs of Administration

As shown in Table II administrative costs, as a per cent of total expenditures, varied between 7.3 and 10.4 per cent over the first four full fiscal years, but dropped to 6.5 per cent in 1953-54. The former collection procedures⁽¹⁾ used in British Columbia, a combination of payroll deduction and direct payment through district offices, were more costly but more appropriate to an industrial province than those

(1) Abolished as of April 1, 1954.

used in Saskatchewan.⁽¹⁾ The cost of administration of the present plan in British Columbia has been estimated at approximately 2.3 per cent and 1.4 per cent of total expenditures for 1954-55 and 1955-56. These percentages do not include the 3% commission paid to vendors collecting the Social Services (i.e. sales) Tax, which is used to finance the Hospital Insurance Service.

METHODS OF PAYMENT TO HOSPITALS

Since the commencement of the plan, payments to hospitals on behalf of eligible patients have been made on the basis of inclusive average patient day costs. In 1949 and 1950, rates were determined, based on estimates submitted by hospitals, and hospitals were paid on the basis of the actual number of days experienced. Such rates were usually considered as provisional and periodic adjustments were required, depending upon actual costs of operation and utilization. Commencing with 1951, a firm budget policy was established and a new method of payment to hospitals was developed. Briefly, the hospital's annual expenditure, as represented by its per diem rate (i.e. the estimate of total expenditures divided by patient days), is now considered to be made up of two components: the fixed costs of operation,

(1) In the latter province, where municipal authorities act as collection agencies on a commission basis, administration costs represented 4.0, and 3.7 and 4.0 per cent of total expenditures, in the years 1952, 1953 and 1954 respectively.

known as the "stand-by costs", which do not vary directly with the patient load; and the so-called "variable supply costs" which represent the estimated costs of food, drug, medical, surgical, and other supplies which vary more or less directly in relation to the number of patient days. Under this method, the hospital is paid monthly a stand-by rate for the estimated patient days, based on the approved budget, and a variable supply rate (e.g. \$1.75 to \$2.75) for all days of care provided in the preceding month. Additional year-end adjustments are made for fluctuations in earnings (e.g. bad debts, special allowances) or in expenditures for certain items.

A Hospital Rate Board, comprising the Commissioner (Chairman), the Hospital Finance Manager, the Hospital Consultation and Inspection Service Manager, and other non-voting advisory members, is responsible for reviewing all hospital budgets, setting the per diem rates and making recommendations concerning the overall expenditure programs of the hospitals.

ADMINISTRATION

The program is administered by a Commissioner of Hospital Insurance, directly responsible to the Minister of Health and Welfare. The Department provides advisory consultive services on hospital construction, personnel, administration and inspection, medical services, and accounting. The Hospital Finance Division is responsible for

accounting and claims and the general overall financial review of the operation of hospitals. The organizational structure also includes Research and Eligibility Divisions. The total administrative staff is now less than 100 persons, as compared to about 480 persons under the former scheme when special divisions were required to administer registration and collection functions.

Although the program is administered centrally through a government agency, the ownership and operation of hospitals remain a local responsibility.

TABLE II - AMOUNT AND PERCENTAGE DISTRIBUTION OF RECEIPTS AND DISBURSEMENTS OF THE HOSPITAL INSURANCE FUND, FISCAL YEARS 1948-49

(Excluding Grants and Advances for Construction and Equipment of Hospitals)

Item	1948-1949		1949-1950	
	Amount	Per Cent	Amount	Per Cent
<u>Receipts</u>	\$		\$	
Personal Premiums	6,092,000	92.0	10,622,474	59.3
Municipal Per Diem Grants	-	-	712,388	4.0
Other	-	-	-	-
Sub Total	6,092,000	92.0	11,334,862	63.3
Subventions and Other Receipts from Consolidated Revenue Fund				
Premiums re Public Assistance Cases Hospitalization of Public Assistance Cases	150,284	2.3	761,489	4.2
Provincial Per Diem Grants	-	-	-	-
Advances from Stabilization Fund	326,502	4.9	1,362,703	7.6
Subsidy	50,000	.8	1,950,000	10.9
Amounts paid into Fund as Premiums on behalf of Residents of Province	-	-	2,500,000	14.0
Total Receipts from Consolidated Revenue Fund	-	-	-	-
	526,786	8.0	6,574,192	36.7
Total Receipts	6,618,786	100.0	17,909,054	100.0
<u>Disbursements</u>				
Payments to Hospitals ^(e)	2,017,070		16,532,855	
Adjustment re Advances) Add	-		2,939,023	
to Hospitals) Deduct	-		-	
Net Payments to Hospitals ^(f)	2,017,070	73.1	19,471,878	92.7
Administration (net)	741,382	26.9	1,542,182	7.3
Total Net Disbursements	2,758,452	100.0	21,014,060	100.0
Excess of:				
Receipts over Disbursements	3,860,334		-	
Disbursements over Receipts	-		3,105,006	
Adjustment ^(g)	1,445,574		-1,445,574	
Cash Balance of Hospital Insurance Fund as of end of Fiscal Year ^(h)	5,305,908		755,328	

See end of Table for footnotes.

TABLE II - AMOUNT AND PERCENTAGE DISTRIBUTION OF RECEIPTS AND DISBURSEMENTS OF THE
HOSPITAL INSURANCE FUND, FISCAL YEARS 1950-51

(Excluding Grants and Advances for Construction and Equipment of Hospitals)

Item	1950-1951		1951-1952	
	Amount	Per Cent	Amount	Per Cent
<u>Receipts</u>	\$		\$	
Personal Premiums	11,439,378	61.5	15,302,706	70.9
Municipal Per Diem Grants	655,973	3.5	933,370	4.3
Other	-	-	-	-
Sub Total	12,095,351	65.0	16,236,076	75.2
Subventions and Other Receipts from Consolidated Revenue Fund				
Premiums re Public Assistance Cases Hospitalization of Public Assistance Cases	1,041,488	5.6	1,406,552	6.5
Provincial Per Diem Grants	-	-	-	-
Advances from Stabilization Fund	1,420,683	7.6	1,427,094	6.6
Subsidy	-	-	-	-
Amounts paid into Fund as Premiums on behalf of Residents of Province	4,045,696	21.7	2,500,000	11.6
Total Receipts from Consolidated Revenue Fund	-	-	-	-
	6,507,867	34.9	5,333,646	24.7
Total Receipts	18,603,218	100.0	21,569,722	100.0
<u>Disbursements</u>				
Payments to Hospitals ^(e)	18,005,065		17,114,825	
Adjustment re Advances) Add to Hospitals) Deduct	-		-	
	-1,934,062		-618,741	
Net Payments to Hospitals ^(f)	16,071,003	90.6	16,496,084	89.6
Administration (net)	1,671,154	9.4	1,908,576	10.4
Total Net Disbursements	17,742,157	100.0	18,404,660	100.0
Excess of:				
Receipts over Disbursements	861,061		3,165,062	
Disbursements over Receipts	-		-	
Adjustment ^(g)				
Cash Balance of Hospital Insurance Fund as of end of Fiscal Year ^(h)	1,616,389		4,781,451	

See end of Table for footnotes.

TABLE II - AMOUNT AND PERCENTAGE DISTRIBUTION OF RECEIPTS AND DISBURSEMENTS OF THE HOSPITAL INSURANCE FUND, FISCAL YEARS 1952-53

(Excluding Grants and Advances for Construction and Equipment of Hospitals)

Item	1952-1953		1953-1954	
	Amount	Per Cent	Amount	Per Cent
<u>Receipts</u>	\$		\$	
Personal Premiums	14,882,289	58.1	14,001,001	57.1
Municipal Per Diem Grants	977,137	3.8	981,482	4.0
Other	-	-	26,323 ^(b)	.1
Sub Total	15,859,426	61.9	15,008,806	61.2
Subventions and Other Receipts from Consolidated Revenue Fund				
Premiums re Public Assistance Cases Hospitalization of Public Assistance Cases	-	-	-	-
Provincial Per Diem Grants	3,546,278 ^(a)	13.8	3,868,165 ^(a)	15.8
Advances from Stabilization Fund Subsidy	1,520,171	5.9	1,614,549	6.6
Amounts paid into Fund as Premiums on behalf of Residents of Province	-	-	-	-
Total Receipts from Consolidated Revenue Fund	4,686,990	18.3	4,033,428	16.4
Total Receipts	9,753,439	38.0	9,516,142	38.8
	25,612,865	100.0	24,524,948	100.0
<u>Disbursements</u>				
Payments to Hospitals ^(e)	21,309,964		24,003,801	
Adjustment re Advances) Add to Hospitals) Deduct	44,322		405,111	
Net Payments to Hospitals ^(f)	21,354,286	92.1	23,598,690	91.1
Administration (net)	1,823,055	7.9	1,653,742	6.9
Total Net Disbursements	23,177,361	100.0	25,252,432	100.0
Excess of:				
Receipts over Disbursements	2,435,504		-	
Disbursements over Receipts	-		727,484	
Adjustment ^(g)				
Cash Balance of Hospital Insurance Fund as of end of Fiscal Year ^(h)	7,216,955		6,489,471 ^(h)	

See end of Table for footnotes.

TABLE II - AMOUNT AND PERCENTAGE DISTRIBUTION OF RECEIPTS AND DISBURSEMENTS OF THE
HOSPITAL INSURANCE FUND, FISCAL YEARS 1954-55

(Excluding Grants and Advances for Construction and Equipment of Hospitals)

Item	1954-55 (Estimate)		1955-56 (Estimate)	
	Amount	Per Cent	Amount	Per Cent
<u>Receipts</u>	\$		\$	
Personal Premiums	Nil ^(c)	-	Nil ^(c)	-
Municipal Per Diem Grants	990,000	3.4	1,040,000	3.5
Other	-	-	-	-
Sub Total	990,000	3.4	1,040,000	3.5
Subventions and Other Receipts from Consolidated Revenue Fund				
Premiums re Public Assistance Cases Hospitalization of Public Assistance Cases	-	-	-	-
Provincial Per Diem Grants	1,650,000	5.6	1,760,000	5.9
Advances from Stabilization Fund	-	-	-	-
Subsidy	-	-	-	-
Amounts paid into Fund as Premiums on behalf of Residents of Province	26,725,000	91.0	26,916,242	90.6
Total Receipts from Consolidated Revenue Fund	28,375,000	96.6	28,676,242	96.5
Total Receipts	29,365,000	100.0	29,716,242	100.0
<u>Disbursements</u>				
Payments to Hospitals ^(e)				
Adjustment re Advances) Add to Hospitals) Deduct				
Net Payments to Hospitals ^(f)	28,700,000	97.7	29,300,000	98.6
Administration (net)	665,000	2.3	416,242	1.4
Total Net Disbursements	29,365,000	100.0	29,716,242	100.0
Excess of:				
Receipts over Disbursements				
Disbursements over Receipts				
Adjustment ^(g)				
Cash Balance of Hospital Insurance Fund as of end of Fiscal Year ^(h)				

See next page for footnotes.

TABLE II - FOOTNOTES

- (a) Represents direct payments to the Fund, including co-insurance, rather than premium payments on behalf of public assistance recipients as in former years.
- (b) Sales of equipment.
- (c) Social Services Tax substituted for individual premium payments, April 1st, 1954.
- (d) Since April, 1954, the public assistance group have not been distinguished, for accounting purposes, from other beneficiaries.
- (e) Represents expenditures by hospitals.
- (f) Represents net cash payments to hospitals in each fiscal year. Figure for 1948-49 represents payments from January 1st, 1949 to March 31st, 1949 only.
- (g) Amusement Tax erroneously paid into Fund in 1948-49, paid into Hospital Construction Fund in 1949-50.
- (h) Disposition of Fund (\$6,510,950, including \$21,479 from sales of equipment):
Refund of premiums paid in advance for periods subsequent to April 1, 1954 - \$3,887,135; Repayment of advances to Consolidated Revenue Fund - \$2,000,000; Balance transferred to Consolidated Revenue Fund - \$623,815.

PUBLIC HOSPITALIZATION PROGRAMS IN ALBERTA

The Province of Alberta has developed two basic programs for hospital care for municipal residents, and additional public programs for maternity patients and persons suffering from diseases such as cancer and poliomyelitis. The Province's Municipal Hospital Plan and Maternity Hospitalization Plan have no counterparts in other provinces. Apart from relatively small revenues received from tenants or non-ratepayers, the Municipal Hospitals Plan is financed by a combination of general provincial revenues and special local taxes on real property. The Maternity Hospitalization Plan, however, is supported solely from the general revenues of the province. In 1953, these two schemes involved a financial commitment of about \$4 million by the province and about \$2 million by the municipalities. When the province's general statutory grants to hospitals, and its special payments for public assistance recipients as well as for cancer and poliomyelitis, are also taken into account, it is estimated that provincial and municipal payments⁽¹⁾ amounted to over \$10 million in 1953, representing almost one-half of the \$21 million⁽²⁾ received as operating revenues by the general

(1) Municipal payments to hospitals for care of the indigent sick are not included here, nor are any payments to hospitals to cover operating deficits.

(2) This figure includes over \$770,000 paid by patients to hospitals in the form of \$1.00 per day payments for standard ward care and \$1.00 per day for special services, as described on Pages 41 and 44. An unknown proportion of this \$770,000 is included in the \$1 million paid by the Alberta Blue Cross plan in hospital benefits in 1953.

hospitals of Alberta from all sources in that year. These facts indicate the financial importance that such schemes have for both the hospitals and the public in Alberta.

COVERAGE

THE MUNICIPAL HOSPITALS PLAN

In recent years, the Municipal Hospitals Plan of Alberta, which began with a single hospital in 1919, has been rapidly expanded until in 1955 it is available in 173 municipalities and municipal hospital districts, which contain 96 per cent of the population of the province, excluding only a few outlying areas. There are two types of benefit program under the plan, one designed to provide standard ward services, and a supplementary scheme to cover "extra" or special hospital services. While most urban areas participate in both programs, the majority of rural municipalities have to date participated with the province in the standard ward care program only. It has been estimated that about 75 per cent of all residents are covered for the standard ward care benefits. No estimate of coverage under the special benefits program is available at present.

All ratepayers, their spouses and dependents under 16 years, are compulsorily covered if they reside either

within a municipal hospital district⁽¹⁾ which has agreed with the province to provide either standard ward services or the complete program through a municipally-owned active treatment hospital, or in a local municipality which has an agreement with an approved hospital to provide the services required. Ratepayers are eligible for such benefits by reason of the payment of the special real property levy which was developed by municipalities as a condition of participating in the program.⁽²⁾ Resident non-ratepayers⁽³⁾ and their dependents⁽⁴⁾ are eligible to purchase hospital service contracts

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- (1) Upon petition from the Council of each municipality, or 25 per cent of the resident ratepayers in each city, town or village (in municipal districts or improvement districts) which it is proposed to include in a hospital district, the Minister of Health may establish a hospital district. If it is considered advisable, the Minister may establish such a district whether or not he has received any such petition or, at his discretion, may modify the boundaries of a proposed hospital district.
 - (2) Since eligibility for benefits under the Hospital Plan is contingent upon the payment of a tax on real property, a ratepayer cannot lose his eligibility status by moving his home from one municipality to another. If he does not purchase property in the municipality to which he has moved, however, he would be required to purchase a hospital contract as a non-ratepayer to retain his eligibility for benefits, or return to the hospital where his first property entitles him to service.
 - (3) Residence in a municipality is achieved by maintaining domicile for 12 consecutive months out of the 24 consecutive months immediately preceding hospitalization.
 - (4) The maximum age for dependent children under non-ratepayer contracts varies from one municipality to another, generally ranging from 16 to 21 years.

from their municipality of residence on a voluntary basis, and obtain the same type of standard ward care and special services that is available to ratepayers. Those who have purchased contracts are eligible for benefits beginning 60 days after the date of the initial purchase of the contract. For ratepayers, there are no such waiting periods; they become eligible for benefits as soon as their names appear on the tax roll. Coverage under the standard ward plan is, however, a prerequisite to obtaining coverage under the special benefits scheme.

Certain classes of persons are excluded under this program. Public assistance recipients and their dependents (including former means test pensioners now on Old Age Security and certain other Old Age Security pensioners, and recipients of Old Age Assistance, Blind Persons' Allowances, Mothers' Allowances, and those receiving a Widow's Pension) obtain all necessary hospital services, without charge, under a special health care program⁽¹⁾ developed by the province for this group. Also excluded are any persons whose hospitalization is the responsibility of the federal government,

(1) In addition to complete standard ward hospital services, persons covered under this program are entitled to full medical, surgical and obstetrical care from general practitioners and specialists, dental care, optical services including refractions and glasses, and special nursing care when approved by the Department. Prescribed drugs for non-hospitalized patients, artificial limbs and ambulance services are not provided under the program

such as members of the armed forces and certain veterans; these persons may cover their dependents, however, if they are ratepayers or have purchased hospital contracts on their behalf. The plan of course has no responsibility for patients in hospital under the provisions of the Workmen's Compensation Act, or of the legislation providing services for poliomyelitis, cancer or arthritis.

MATERNITY HOSPITALIZATION PLAN

Since 1944, under the Maternity Hospitalization Act, expectant mothers who reside and have resided in the province for twelve consecutive months out of the 24 months immediately preceding confinement, are eligible to receive specified maternity hospitalization services, up to a maximum period of 12 days. Since 1949, women residing in the province at the time of admission to hospital, but unable to meet the residence requirement themselves, have been able to attain eligibility under this scheme, if their husbands are qualified residents.

BENEFITS

THE MUNICIPAL HOSPITAL PLAN

The benefits provided under the standard ward care program vary somewhat between hospitals, but always cover public ward accommodation, meals, nursing care, drugs, and medications and dressings ordinarily provided, without extra charge. Admission for observation and diagnosis is

permitted, and hospitalization in active treatment hospitals outside the patient's municipality of residence, or outside the province, is provided for referred or emergency cases.⁽¹⁾ There are no exclusions for pre-existing conditions and no limit on the length of stay in hospital as long as active treatment is required.

In some 105 municipalities and hospital districts participating in the special benefits program,⁽²⁾ extra services, including laboratory examinations, X rays, operating room facilities, and special drugs, with no additional charges, are made available to those persons covered under the standard ward care program. The range of benefits under the special benefits scheme includes all hospital procedures, treatments, drugs, and medications and dressings not included among the standard ward care benefits, except the following:

(1) Hospitalization outside the province for such cases was not provided until April, 1954. After April, 1955, all local authorities were required to provide this benefit. In cases of emergency hospitalization within or without the province, the responsible municipality, on medical evidence, reimburses the patient up to an amount equivalent to what would have been paid on his behalf if he had been hospitalized locally. For cases medically-referred to another hospital, the patient's physician must first provide the local authority with acceptable evidence of need for referral. The patient is then given written authority permitting the referred hospital to bill the local authority up to a specified amount not exceeding local per diem rates.

(2) Introduced July 1, 1953.

- | | |
|---|--|
| (a) Private and semi-private ward accommodation. | (d) Cortisone and ACTH, cortate and estrogen implant, heparin, and any new drugs placed on the market since June 30, 1953. |
| (b) Procedures, treatments, and tests not available in the hospital in which the patient is being hospitalized. | (e) Anaesthetist services. |
| (c) Appliances primarily intended for the use of the patient after discharge. | (f) Electroencephalograph examinations. |

THE MATERNITY HOSPITALIZATION PLAN

Benefits under the maternity program include public ward accommodation; use of the case room including anaesthetic materials and intravenous medications; laboratory services; routine drugs and dressings; and feeding of the infant. A maximum benefit period of twelve days hospitalization applies to both mother and infant⁽¹⁾ and includes the day of delivery of an infant born after a period of at least 28 weeks gestation.

Special alternative provisions have been made to provide maternity benefits to a mother who has arranged for maternity services in her own home, or who has been confined in an Alberta hospital which has not written an agreement with the province, or in a hospital in an adjoining province where a hospital within the province is not readily available to her. In the case of home confinement, an eligible woman may, upon application, receive a cash payment of \$40. In the case of hospitalization outside the province, an eligible woman, upon submission of her receipted hospital account, may

(1) But see p. 42, n. 1.

receive a payment from the province representing the daily payments which would normally have been made on her behalf to a hospital nearest to her place of residence. A grant, set by regulation, may similarly be made in cases where maternity services were provided by hospitals which have not made the necessary agreements with the province under this program.

It should be mentioned that a person may elect to take no advantage whatsoever of the "free" benefits provisions of the Act and assume the entire responsibility for the full costs of hospitalization. Usually, however, eligible patients will arrange with the hospital to assume only that portion of the total hospital bill representing the difference in cost between a semi-private or private room and public ward accommodation, plus, of course, the cost of any ancillary or additional services not included under the maternity program.

UTILIZATION

Before analyzing the utilization experience of the various hospital programs operating in the province, it is helpful to consider the over all pattern of hospital utilization for the province as a whole. Table 1 indicates the extent of hospitalization in a province with the second most favourable bed supply in Canada, and with about 75 per cent of its population protected against the major portion of their hospital bills. It will be noted that from 1950 to

1954, the utilization of general hospital beds, as represented by separation rates,⁽¹⁾ has increased steadily. The increase in the number of separations per thousand population, about 15 per cent over these years, is generally the same as the all-Canada rate, but the 1953 level of utilization, 192 cases per thousand, represented the second highest rate among all provinces.⁽²⁾ On the other hand, the average length of stay per case in Alberta remained almost unchanged over the same period 1948-53; the 1953 average of 8.8 days was lower than in any other province except Manitoba.⁽³⁾ Hospital days provided per thousand of population increased at a steady rate and by 1953 reached an average of 1,743, a rate only exceeded in the province of Saskatchewan.

While a variety of factors⁽⁴⁾ affect the volume of hospitalization in any province, the bed supply and the

-
- (1) Discharges and deaths, excluding newborns, per 1,000 population.
- (2) The highest rate was experienced in Saskatchewan with 206 cases per 1,000 in 1953. The all-Canada rate was only 123 cases per 1,000 in 1953.
- (3) See D.B.S. Hospital Statistics, Vol. 1, 1953. Low average stay in Alberta, a long-term experience, may be affected by the high proportion of relatively short-stay maternity cases, and the fact that the Municipal Plan will reimburse hospitals for short-term cases admitted for observation and diagnosis only. Also, the fact that females 45 years and over in Alberta are slightly under-represented (22 per cent of the female population as compared to 25 per cent for Canada), may help to reduce Alberta's average stay figures, since the hospital days of such persons usually exceed, in relative terms, the proportion they represent of all females in the population.
- (4) Including the demographic characteristics of the population; ease of transportation; size, type and distribution of hospitals; admission-discharge policies; hospital occupancy rates, turnover intervals, and so on.

economic arrangements under which patients purchase hospital care have often been cited as two of the most significant. Considering hospital rates in Alberta, then, it seems important to note that Alberta's bed supply in general hospitals, which in 1948 was exceeded only by that of Saskatchewan, has continued to improve over the period 1949 to 1953. Furthermore, coverage under the Municipal Plan over these years increased from 35 per cent of the population in 1948 to about 75 per cent in 1953.

TABLE 1 - HOSPITAL UTILIZATION IN ALBERTA,
1949 TO 1954(a)
(Public General Hospitals Only)

Year	Beds Set Up Per 1000 Total Population	Separation Rates(b) Per 1000 Total Population	Hospital Days(c) Per 1000 Total Population	Average(c) Days of Stay Per Case
1949	6.2	174	1,566	8.8
1950	6.0	172	1,568	8.8
1951	6.5	176	1,582	8.9
1952	6.2	187	1,640	8.8
1953	6.5	192	1,682	8.8
1954	6.5	196	1,743	8.9

(a) Not adjusted for a few beds in non-reporting hospitals.

(b) Based on discharges and deaths, excluding newborns.

(c) Based on patient days during the year, excluding newborns.

Source: Based on data provided by the Alberta Department of Public Health, and D.B.S. Annual Reports of Hospitals, 1949 to 1952, and Hospital Statistics, Vol. I, 1953.

THE MUNICIPAL HOSPITALS PLAN

Since the introduction of provincial grants in June 1950, the municipal hospital schemes have accounted for a steadily increasing proportion of the total days of care provided in Alberta hospitals. In seven months of 1950, about 14 per cent of hospital days in Alberta were received by persons enrolled under the Municipal Hospitals Plan; by 1954 this proportion had increased to almost 40 per cent, as shown in Table 2.

Over the period 1951 to 1954, although the number of separated cases had almost doubled (47,000 to 92,000 cases), the average length of stay in hospital of each case remained almost the same - 7.6 days in 1951, and 7.8 days in 1954.

Since no accurate count of persons covered under this program is available, it is impossible to obtain hospitalization rates and hospital days per 1,000 beneficiaries. However, on the assumption that 75 per cent of the 1954 population were enrolled with these municipal schemes, it is estimated that in that year there were about 120 separations per 1,000, as compared with 196 for the whole population, and that about 925 hospital days were provided per 1,000 beneficiaries, as compared with 1,743 days for the whole population. It should be noted, of course, that, in addition to these days of care, persons covered under this program may also have accounted for some of the days of care provided

under the special provincial programs for maternity, poliomyelitis, cancer and arthritis cases. Furthermore, the provincial rate of 1743 days per thousand is considerably affected by the relatively high rate of utilization of public assistance cases.

TABLE 2 - UTILIZATION OF PUBLIC GENERAL HOSPITALS UNDER MUNICIPAL HOSPITAL PLAN, 1950 TO 1954

Year	Benefit Program	Total Days of Care	Number of Separated Cases	Average Days of Stay Per Separated Case	Percent of Total Hospital Days
1950	Standard Ward(a)	113,441	(b)	(b)	13.9
1951	Standard Ward	357,321	46,779	7.6	24.0
1952	Standard Ward	500,006	65,862	7.6	31.4
1953	Standard Ward	553,666	72,372	7.6	32.3
	Complete Care(c)	106,802	13,154	8.1	6.2
	Total	660,468	85,526	7.7	38.5
1954	Standard Ward	353,744	44,818	7.9	19.5
	Complete Care	367,822	47,442	7.75	20.3
	Total	721,566	92,260	7.8	39.8

(a) For a seven-month period only.

(b) Not available.

(c) Six months only.

Source: Data provided by Alberta Department of Public Health.

THE MATERNITY HOSPITALIZATION PLAN

In the past two years about 91 per cent of all maternity cases in the province have taken advantage of the benefits available under the maternity plan.⁽¹⁾ The number of hospitalized confinements per 1,000 population has increased slightly during the last few years - from 25.5 to 29.2 per thousand between 1951 and 1954, as Table 3 indicates; at the same time the average length of stay in hospital was falling - from 8.4 days to 7.8 days per case - a continuation of the trend which has been evident since 1945 when the average stay was 10.3 days per case.

TABLE 3 - UTILIZATION OF PUBLIC GENERAL HOSPITALS
UNDER MATERNITY HOSPITALIZATION PLAN,
1951 TO 1954

Year	Number of Confinements Per 1000 Total Population	Hospital Days Per 1000 Total Population	Average Days of Stay Per Case	Percent of Total Hospital Days
1951	25.5	214	8.4	13.5
1952	26.8	219	8.2	13.4
1953	27.9	219	7.9	13.0
1954	29.2	228	7.8	13.1

Source: Based on data provided by Alberta Department of Public Health.

- (1) Since 1949, over 95 per cent of live births to Alberta residents have taken place in hospital. In 1953 the percentage of institutional births in Alberta, 96.5 per cent excluding Indians, was exceeded only in British Columbia, and compared very favourably with the all-Canada figure of 83.4 per cent. Before the introduction of the maternity hospitalization program in 1944, the proportion of institutional births in Alberta was already second highest in the country at 83 per cent. Since 1944, all provinces have experienced an upward trend in the proportion of hospitalized births.

HOSPITALIZATION OF PUBLIC ASSISTANCE RECIPIENTS

A third public program providing hospital care to Alberta residents is the special scheme for public assistance recipients. In 1954 this program accounted for almost as many hospital days as the maternity program - 12.4 per cent of total days. As Table 4 indicates, public assistance recipients, most of whom were in the age group over 65 years, received hospital care at an estimated rate of 6675 days per 1000, as compared with 1743 days per 1000 for the province as a whole. Since 1951 there has been a general increase in the rate of hospitalization of this group.

Probably the most important characteristic of hospital care provided to this group of beneficiaries is the average length of stay in hospital of such cases. The average public assistance case remained in hospital almost twice as long as the average stay per case under the municipal hospital plan in 1954 - 15 days per case as compared with 7.8 days. This greater length of stay accounts to a great extent for the higher average length of stay for the whole province - 8.9 days per case, as given in Table 1.

TABLE 4 - UTILIZATION OF PUBLIC GENERAL HOSPITALS BY
PUBLIC ASSISTANCE RECIPIENTS, 1951 TO 1954

Year	Number of Recipients Per 1000 Population	No. of Hospital Days		Average Days of Stay Per Case	Percent of Total Hospital Days
		Per 1000 Total Population	Per 1000 P.A.(a) Recipients		
1951	28.5	165	5,780	15.5	10.4
1952	31.7	190	5,990	15.2	11.6
1953	32.0	207	6,495	15.5	12.3
1954	32.5	216	6,675	15.0	12.4

(a) Estimated

Source: Based on data provided by Alberta Department of Public Health.

SUMMARY OF ALL PROGRAMS

All the provincial hospitalization programs taken together (including poliomyelitis cases from 1953 on) accounted for over 70 per cent of all days in Alberta hospitals in 1954, as compared with 1951 when 48 per cent of the days were provided under such programs. This increase is due largely to the expansion of the Municipal Hospital program, as Table 5 indicates, but also to the introduction of a separate program for poliomyelitis patients in 1953. This latter group experienced an average stay in hospital of 86 days per case in 1954. Public assistance recipients were second in duration of stay in hospital, while non-grant patients (Indians, veterans, and non-residents) were third with a rate of stay only slightly above the provincial average.

TABLE 5 - AVERAGE DAYS OF STAY PER CASE AND PERCENTAGE
DISTRIBUTION OF TOTAL HOSPITAL DAYS, BY TYPE
OF PROGRAM, 1951 TO 1954

Year	Municipal Hospital Plan	Maternity Hospital- ization Plan	Public Assist- ance Recipients Program	Polio- myelitis Cases	Other(a) Per Diem Grant Patients	Non-(b) Grant Patients	All Patients
Average Days of Stay Per Case							
1951	7.6	8.4	15.5	(c)	8.0	12.1	8.9
1952	7.6	8.2	15.2	(c)	7.8	10.7	8.8
1953	7.7	7.9	15.5	62.9	7.6	9.7	8.8
1954	7.8	7.8	15.0	86.2	7.6	9.2	8.9
Percentage of Total Hospital Days							
1951	24.0	13.5	10.4	(c)	52.1		100.0
1952	31.4	13.4	11.6	(c)	43.6		100.0
1953	38.5	13.0	12.3	4.4	31.8		100.0
1954	39.8	13.1	12.4	5.1	29.6		100.0

(a) Includes self-payment, insurance, indigent, and Workmen's Compensation Board cases.

(b) Includes non-residents and patients who are under Federal responsibility, as well as psychiatric cases in general hospitals and non-treatment cases.

(c) Prior to 1953 only a limited program of care for patients suffering from the after-effects of poliomyelitis was in operation.

Source: Based on data provided by Alberta Department of Public Health.

FINANCES

THE MUNICIPAL HOSPITALS PLAN

The cost of hospitalization under both types of benefit program, standard ward and special services, are shared between the patient, the province and the municipality or municipal hospital district. Since the financial arrangements vary somewhat as between the two schemes, the programs are discussed separately below.

1. Standard Ward Care Program

Under this scheme the patient, either ratepayer or contract holder, is required to pay a maximum of \$1 per day for each day's hospitalization. After the patient's share has been deducted, the municipality of residence pays the remainder of the charges, established by regulation, for standard ward care to the Hospital Board operating the hospital providing care to the beneficiary. Since June, 1950, the provincial government has reimbursed the municipality for at least half this payment. The charges for standard ward care are based on a special scale of rates, which vary by class of hospital from \$8.25 per day for Group A hospitals to \$6.00 a day for Group E hospitals, with lower rates in the case of

children under 16 years.⁽¹⁾ The provincial government reimburses the municipality for 50 per cent of its payment on behalf of covered residents if only the standard ward care program is offered, or for 60 per cent if both programs are available to residents.

Municipalities are free to introduce a minimum tax provision, but this tax must not be more than \$10.00 per year per ratepayer. In municipalities which have adopted this provision, ratepayers whose property taxes on the mill rate do not amount to at least \$10.00, or whatever minimum tax has been chosen, must pay the difference up to the minimum tax level.

Provincial payments for contract holders are calculated in a fashion similar to that for ratepayers in municipalities whose family hospital contract rate does not exceed \$10 a year where hospitalization is provided through Group A hospitals, or \$8 a year in other classes of hospitals. Where contract rates exceed these sums, the province will not reimburse the municipality or local authority for hospitalization of such cases.

(1) As of May 1, 1954, hospitals can charge a rate of \$3 00 per day for newborn infants eligible for care under the Maternity Hospitalization Act retained in hospital more than the maximum of twelve days permitted under that Act but less than thirty days from the date of birth. For infants not eligible for care under the Maternity Hospitalization Act, this charge can be made from birth to thirty days. If the mother is covered under the Municipal Hospital Plan, this daily charge is shared equally by parent, municipality and province. After thirty days the regular children's rates are charged.

The provincial hospital grants are paid out of general provincial revenues, and the payments made by participating municipalities from special mill rate hospital taxes. The municipal tax on real property is calculated in such a way as to provide, together with revenues from the sale of contracts to non-ratepayers,⁽¹⁾ a sum equal to the municipal share of the per diem rate for standard ward benefits, after deduction of the \$1 a day patient payments. Each month a municipality, or the Board of any Municipal Hospital District, is reimbursed by the province in the manner described above for the days of care rendered to eligible patients under this program.⁽²⁾ In addition to this provincial support, all hospitals in the province receive a general grant of \$1.00⁽³⁾ paid by the province for each day any resident is hospitalized. This latter statutory grant, a traditional form of provincial subsidy to all hospitals, is of course paid on behalf of all patients, whether or not they are entitled to benefits under the Municipal Plan.

(1) In 1952, revenues from the sale of hospital contracts amounted to about 1.5 per cent of the total operating revenues of 51 municipal hospitals. This excludes non-municipal hospitals, such as those in Calgary and Edmonton.

(2) Where the person who receives hospitalization is a ratepayer in two or more municipalities and these municipalities have agreements with the hospital under the Plan, the hospital is required to bill the municipality of residence. Where such person has no municipal residence, he must specify to the hospital which municipality he desires to be responsible for his hospitalization.

(3) Before April 1955, this grant amounted to 70 cents per day.

2. Special Services Program

In 1953, amendments to the Hospitals Act provided for provincial financial participation to meet part of the cost of providing certain special hospital services to eligible residents of municipalities which have made approved agreements with hospitals to provide standard ward care services. As in the case of the standard ward care program, the province may reimburse the municipality or the Municipal Hospital District for a portion of the sum paid to a participating hospital by the municipality, but not exceeding certain daily maxima. For purposes of establishing the amounts to be paid by the province, maximum per diem rates have been set, ranging from a total of \$4 in the case of Group A hospitals, to a total of \$1.20 in Group E hospitals. The patient is required to pay 25 per cent of these rates, but not more than \$1.00 per day, for the special hospital services he has received. The remainder of the per diem rate is met by the municipality, which is reimbursed by the province for sixty per cent of this expenditure.⁽¹⁾ In addition to this payment, the province makes a statutory grant of 50 cents per patient day (over and above the \$1.00 per diem grant mentioned in the previous section) to any hospital which participates in the special services program. Thus for a day's care in a Group A hospital, with rates of \$8.25 per

(1) Before April, 1955, a 50 per cent reimbursement was made.

day for standard ward care and \$4.00 per day for special services, or a total rate of \$12.25 per day, the following amounts would be paid:

By the Patient:	for standard ward care	\$1.00
	for special services (at 25% of daily rate)	\$1.00
By the Municipality of Residence:		
	40 per cent of daily rate less patient payments	\$4.10
By the Province:	60 per cent of daily rate less patient payments	\$6.15
	Total	<hr/> \$12.25

When the statutory payment from the province of \$1.50 is added, the hospital's total per diem receipts amount to \$13.75 for an adult patient.

Where the cost to non-ratepayers of hospital contracts for special hospital services exceeds \$4 per year, in the case of Group A and B hospitals, and \$2 per year in other hospitals, the Municipal Hospital District or local authority is not eligible for reimbursement by the province with respect to such services.

3. Payments Under Municipal Hospitals Plan

Over the past five years, from 1950 to 1954, total financial participation by the provincial and municipal governments has grown from approximately \$490,000 to about \$5.8 million, as shown in Table 6. Furthermore, such

payments exclude municipal grants to cover operating deficits. Increased expenditures in the last three years were mainly due to the inclusion of the city of Edmonton in the plan, and the inception of the Special Services Program. For the year 1953, the expenditure of approximately \$4.6 million includes \$264,000 shared equally between the province and participating municipalities over the six months of operation of the special hospital services program.

TABLE 6 - PUBLIC PAYMENTS TO HOSPITALS UNDER MUNICIPAL HOSPITALS PLAN, 1950 TO 1954

Year	Municipal Payments	Provincial Payments	Provincial Statutory Grants	Total Public Payments	Payments Per Separated Case
	\$	\$	\$	\$	\$
1950	203,000	203,000	79,000	486,000	(a)
1951	683,000	683,000	260,000	1,626,000	34.76
1952	1,317,000	1,317,000	388,000	3,021,000	45.87
1953	2,044,000	2,044,000	479,000	4,567,000	53.40
1954	2,637,000	2,637,000	523,000	5,796,000	62.82

(a) Not available.

Source: Data provided by Alberta Department of Public Health.

THE MATERNITY HOSPITALIZATION PLAN

Hospitals which have entered into agreements with the Minister of Health to provide maternity care to Alberta residents are reimbursed at the following per diem rates, up to a maximum period of twelve days:

Class A	\$8.25 per day plus \$35.00 per case ⁽¹⁾
B	\$6.90 per day plus \$25.00 per case
C	\$6.30 per day plus \$21.00 per case
D	\$6.30 per day plus \$17.00 per case
E	\$6.00 per day plus \$13.00 per case

In addition to these payments, the hospitals receive the regular statutory per diem grants (\$1.00 or \$1.50 after April 1955) for both maternity cases and newborn children.

Payments under the maternity program are entirely financed from general provincial revenues and have increased from about \$450,000 in the first year of the program ending March, 1945, to over \$2 million in 1953-54. About 50 per cent of this increase in payments was due to the increase in the number of cases (and their hospital days) coming under the program, and the remainder to a number of increases over the years in the rate of payment for each day's hospitalization.

The average payment per case, as shown in Table 7, reached \$71.10 by 1953. Including the above-mentioned statutory grants of 70 cents per day, and assuming an average length of stay for maternity cases of eight days, it would appear that the maternity program cost the provincial government a total of about \$76.70 per case in 1953-54.

(1) Before April 1955 the payments per case were \$18, \$13, \$11, \$9, and \$7 for each class of hospital, respectively. These per case payments are intended to insure that hospitals receive adequate payment for short term cases, since the first few days of any confinement are the most costly. The \$35.00 payable to Class A hospitals is designed to allow \$15 for the case room, \$8 for routine laboratory services, drugs and dressings, and \$12 for care and feeding of newborn infants.

TABLE 7 - PAYMENTS UNDER THE MATERNITY HOSPITALIZATION
PLAN 1944 TO 1953

Year	Number of Annual Cases	Payments	
		Total	Per Case ^(a)
1944-45	16,300 ^(b)	\$ 453,860	\$ 27.85
1945-46	17,801	554,690	31.15
1946-47	19,868	697,428	35.10
1947-48	22,706	771,662	34.00
1948-49	22,860 ^(c)	798,724	34.95 ^(c)
1949-50	23,900 ^(c)	940,481	39.35 ^(c)
1950-51	22,675	945,630	41.70
1951-52	24,100	957,108	39.70
1952-53	26,012	1,377,167	52.95
1953-54	28,459	2,023,512	71.10

(a) Approximations only since number of cases are on a calendar year basis while total payments are on a fiscal year basis.

(b) Based on 12,236 cases in the first nine months.

(c) Estimated.

Source: Data provided by Alberta Department of Public Health.

TOTAL PUBLIC PAYMENTS FOR PROVINCIAL HOSPITALIZATION SCHEMES

To consider the magnitude of total governmental payments under the various public hospital programs in Alberta, it is necessary to include the general provincial support given to all hospitals in the province in the form of statutory grants of 70 cents a day until 1955,⁽¹⁾ and the cost of the special schemes for public assistance recipients and cancer and poliomyelitis cases, in addition to payments under the Municipal Hospitals and the Maternity Hospitalization

(1) See p. 43 , n. 3

Plans.⁽¹⁾ With such an all-over approach, it appears that total governmental payments to hospitals for the maintenance of patients (excluding mental and T.B. institutions)⁽²⁾ have increased by 220 per cent between the fiscal years ending 1951 and 1954. Indeed, it will be noted from Table 8 that total payments, both provincial and municipal, of \$10.4 million in 1954 equalled about 49 per cent of the operating revenues of all public general hospitals in Alberta.

A further observation might be made as to the extent to which provincial general revenues are used to finance the six types of arrangements made by the province to assist patients in meeting their hospital bills. Over the past four years provincial payments have accounted for about 82 per cent of the combined provincial and municipal payments. In 1953-54, provincial payments from general revenue reached a total of \$8.2 million, as shown in Table 8, or 79 per cent of the total public payments made under all programs.

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- (1) It should be noted that all such payments are included in one form or another in the financial provisions of the other provinces with public hospital programs, namely, British Columbia, Saskatchewan and Newfoundland.
- (2) In addition, provincial revenues in Alberta assume about 75 per cent of the operating costs of mental and tuberculosis institutions.

TABLE 8. PUBLIC PAYMENTS TO HOSPITALS, BY TYPE OF PROGRAM AND LEVEL OF GOVERNMENT, FISCAL YEARS 1950-51 TO 1953-54

Item	1950-51			1951-52		
	Provin- cial	Munici- pal	Total	Provin- cial	Munici- pal	Total
	\$	\$	\$	\$	\$	\$
Maintenance Payments from Government Funds:						
Municipal Hospitals	259,539	259,539	519,078	648,642	648,642	1,297,284
Maternity Hospitalization Plan	945,630	(a)	945,630	957,108	(a)	957,108
Hospitalization of Public Assistance Recipients	672,608	(a)	672,608	780,416	(a)	780,416
Hospitalization of Cancer Cases	31,300 ^(b)	(a)	31,300 ^(b)	53,000 ^(b)	(a)	53,000 ^(b)
Hospitalization of Poliomyelitis cases	43,100	(a)	43,100	37,712	(a)	37,712
Statutory Grants	1,046,173	(a)	1,046,173	1,154,951	(a)	1,154,951
Total Government Payments	2,998,350	259,539	3,257,889	3,631,829	648,642	4,280,471
Total Operating Income - All Sources ^(d)	\$13,000,000			\$15,000,000		
Government Payments as Percentage of Total Operating Revenues	25			29		

For footnotes see next page.

TABLE 8 (Cont'd)

Item	1952-53			1953-54		
	Provin- cial	Munici- pal	Total	Provin- cial	Munici- pal	Total
	\$	\$	\$	\$	\$	\$
Maintenance Payments from Government Funds:						
Municipal Hospitals	1,352,503	1,352,503	2,705,006	2,216,433	2,216,433	4,432,866
Maternity Hospitalization Plan	1,377,167	(a)	1,377,167	2,023,512	(a)	2,023,512
Hospitalization of Public Assistance Recipients	1,164,340	(a)	1,164,340	1,688,243	(a)	1,688,243
Hospitalization of Cancer Cases	61,900	(a)	61,900	56,682 ^(c)	(a)	56,682 ^(c)
Hospitalization of Poliomyelitis cases	251,563	(a)	251,563	816,276	(a)	816,276
Statutory Grants	1,238,704	(a)	1,238,704	1,384,150	(a)	1,384,150
Total Government Payments	5,446,177	1,352,503	6,798,680	8,185,296	2,216,433	10,401,729
Total Operating Income - All Sources ^(d)	\$17,000,000			\$21,100,000		
Government Payments as Percentage of Total Operating Revenues	40			49		

a) Not applicable.

b) Estimated.

c) Calendar year.

d) Calendar year, as shown in Dominion Bureau of Statistics, Annual Report of Hospitals, 1950, 1951 and 1952, and Hospital Statistics, Vol. II, 1953, for public general hospitals. All figures rounded.

Note: Municipal payments exclude any grants made to local hospitals to cover operating deficits.

Sources: Province of Alberta, Public Accounts, 1950-54; unpublished data, Department of Public Health.

SASKATCHEWAN HOSPITAL SERVICES PLAN

The Saskatchewan Hospital Services Plan (hereinafter referred to as SHSP), which came into effect on January 1, 1947, was the first provincial program to provide a comprehensive prepaid hospital insurance scheme, to almost the entire population, on a compulsory basis. A long history of over three decades of local effort with respect to the development and maintenance of hospitals and experimentation with prepayment plans in local areas preceded the Saskatchewan Hospitalization Act of 1946. The program provides virtually complete in-patient care on a public ward basis, financed by personal premium contributions or taxes and general provincial revenues, including since April 1950, one-third of the proceeds of a three per cent sales tax. The plan, administered through the Medical and Hospital Services Branch of the Department of Public Health, has expended about \$98 million on payments to hospitals over the past eight years.

COVERAGE

SHSP is based on the principle of universal coverage. However, certain groups already in receipt of equivalent hospitalization services from other agencies of the provincial or federal governments are not included, such as members of the Royal Canadian Mounted Police and the armed forces, Treaty Indians, war veterans allowances recipients,

inmates of provincial gaols and federal penitentiaries, and patients in mental hospitals and tuberculosis sanatoria. With the exception of residents of the sparsely settled Northern Saskatchewan Administration District who cannot easily be provided with hospital services, all other persons who have resided in the province for a period of six months are compulsorily covered. In 1954 an average of 810,246 persons, or 92 percent of the provincial population, were covered under the program.

All recipients of the various public assistance programs are covered by the payment of the hospitalization tax on their behalf by the appropriate public agency. Such beneficiaries include the spouses and dependent children or grandchildren under the age of 16 years, (and incapacitated children between 16 and 21 years) of all persons receiving the provincial supplemental (means-test) allowance⁽¹⁾ to the Old Age Security Pension, recipients of old age assistance, and recipients of blind persons' allowance, as well as mothers' allowance cases, wards of the Crown and recipients of social assistance, including local relief cases.

BENEFITS

SHSP provides an almost complete range of in-patient hospital service benefits. Since the Plan began in 1947, services provided have included public ward or minimal

(1) New residents can qualify for such allowances only after one year's continuous residence.

accommodation (including meals, special diets, and general nursing care); the use of operating and case rooms, including anaesthetic supplies and equipment; surgical dressings and casts; x-ray and other diagnostic procedures including laboratory tests; x-ray therapy; physiotherapy; most drugs in general use, and all other services rendered by individuals who receive remuneration from the hospital for such services. Blood for transfusions and certain endocrine and vitamin preparations are not included. The major excluded items are out-patient services, the extra cost of private or semi-private accommodation, the services of doctors or special nurses not employed by the hospital, patent medicines, and a few new and expensive drugs. Hospitalization for diagnostic procedures, and for arthritis or rheumatism in institutions associated with mineral springs or spas is excluded; hospitalization for mental illness, tuberculosis, and work-connected disabilities (under the Workmen's Compensation Act) is provided free of charge under other programs. No limit other than medical necessity is placed on the length of stay in hospital, for either acute or chronic conditions

For beneficiaries hospitalized outside Saskatchewan, cash benefits are paid on a limited indemnity basis (\$1.50 per day for newborns and \$7.50 for other beneficiaries) and are usually limited to 60 days of hospital care per year.

ELIGIBILITY CONDITIONS

All benefits are available only on the basis of medical necessity. There are no restrictions because of age or pre-existing conditons, and no waiting periods for maternity benefits. Eligibility is dependent upon six months residence⁽¹⁾ and the payment of the hospitalization tax, or qualification for provincial assistance. In cases of late payment, e.g. after November 30th for coverage during the following calendar year, eligibility begins one month after the date of payment.

Every person after registration and payment of the tax is provided with a hospital services card. A patient recommended by a physician for hospitalization simply presents his card upon admission.

UTILIZATION

About one beneficiary out of every six was hospitalized during 1954, including over 20 per cent of patients who were hospitalized at least twice during the year, and 5 per cent who were discharged more than twice. If no allowance is made for such multiple admissions, there has been about one discharged case for each five beneficiaries

(1) Newly-arrived dependents of residents may participate immediately if the resident spouse or parent has completed six months' residence, or they may wait until they have completed six months' residence. An insured person who establishes residence outside the province is covered for the duration of the year for which his tax has been paid. Further eligibility requires re-establishment of residence and a six months' waiting period.

under the plan every year since 1949. A range of from 199 to 206 cases per thousand beneficiaries were discharged annually over this six-year period, as Table 1 indicates. However, in the first three years of the program, the discharge rate had climbed rapidly from 156 in 1947 to 200 per thousand beneficiaries in 1949. A similar increase occurred in the number of days in hospital per person: from 1.6 in 1947 to 2.2 in 1951, falling to 2.1 in 1953 and 1954 as a result of a decrease in the average length of stay.

The average length of stay per discharged patient has ranged between 10.0 and 11.1 days under the insurance program. Prior to its inception, the length of stay in Saskatchewan public general hospitals (excluding the newborns) averaged 9.9 days in 1943, 9.8 in 1944 and 1945, and 10.0 in 1946. Under SHSP, average length of stay per discharged case increased fairly steadily from 10.0 in 1947 to 11.1 in 1951, and then fell gradually to 10.2 days in 1954, as shown in Table 1. In considering this generally higher average length of stay under the insurance scheme, it should be mentioned that in 1954, as formerly, patients who remained in hospital ten days or less, while representing nearly three-quarters of all cases discharged, accounted for just over one-third of all patient days. On the other hand, patients in hospital over 21 days, who comprised roughly one-tenth of all cases, received over two-fifths of all days of care.

Table 1. GENERAL HOSPITAL UTILIZATION RATES,
S.H.S.P., 1947 TO 1954

Year	Rated Bed Capacity per 1,000 Population (a)	Discharged Cases per 1,000 Covered Persons	Average Length of Stay per Discharged Case (b)	Hospital Days for Discharged Cases per 1,000 Covered Persons	Days Per Bed
1947	4.9	156	10.0	1,565	306
1948	5.3	178	10.5	1,875	319
1949	5.9	200	10.3	2,048	312
1950	6.4	203	10.8	2,197	314
1951	6.6	199	11.1	2,201	304
1952	6.7	205	10.6	2,175	292
1953	6.6	206	10.4	2,139	290
1954	6.4	204	10.2	2,084	288

(a) Excluding beds in mental, tuberculosis and federal institutions. Rated bed capacity represents the average number of beds per year which hospitals are designed to accommodate, based on minimum standards of floor space per bed, and not the actual beds set up.

(b) Adults and children only, excludes newborns.

Source: Annual Report of the Saskatchewan Hospital Services Plan, 1954,
(Regina: Dept. of Public Health, 1955), Tables I, III, V and VIII.

The 204 discharged cases per thousand covered persons in 1954 have been broken down in Table 2 according to the primary cause of hospitalization. The most frequent cause by far was childbirth and complications of pregnancy, accounting for 38 cases per thousand covered persons or 79 per thousand females. "Other specified and ill-defined diseases" accounted for 17 cases per thousand, while "accidents, poisonings, and violence" and "acute pharyngitis and tonsillitis and hypertrophy of tonsils and adenoids" accounted for 16 and 15 cases per thousand covered persons respectively. In fifth and sixth place in order of frequency were diseases of the genital organs, and pneumonia, each with 8.9 cases

per thousand. The residual categories "other diseases of the digestive system" and "other respiratory diseases" ranked seventh and eighth, accounting for 7.2 and 5.8 cases respectively, appendicitis with 5.6 cases ranked ninth, and diseases of the gall bladder, with 4.9 cases per thousand, ranked tenth. The remaining forty categories cover diagnoses of conditions each of which caused hospitalization of less than 5 cases per thousand covered persons in 1954.

Table 2. NUMBER OF DISCHARGED CASES PER THOUSAND COVERED PERSONS BY PRIMARY DIAGNOSIS (a), EXCLUDING NEWBORNS, S.H.S.P., 1954.

List No.(a)	Primary Diagnosis	Rate per 1,000 Covered Persons	List No.(a)	Primary Diagnosis	Rate per 1,000 Covered Persons
C 1	Tuberculosis of Respiratory System	0.08	C12	Malignant Neoplasms, Including Neoplasms of Lymphatic and Haematopoietic Tissues	4.34
C 2	Tuberculosis, Other Forms	0.04			
C 3	Syphilis and its Sequelae	0.05			
C 4	Gonococcal Infection	0.01			
C 5	Dysentery, All Forms	0.08	C13	Benign Neoplasms and Neoplasms of Unspecified Nature	4.49
C 6	Other Infective Diseases Commonly Arising in Intestinal Tract	0.12	C14	Allergic Disorders	3.07
			C15	Diseases of Thyroid Gland	0.95
C 7	Certain Diseases Common Among Children		C16	Diabetes Mellitus	1.95
C7a	Scarlet Fever	0.06	C17	Avitaminosis and Other Deficiency States	0.17
C7b	Diphtheria	0.01	C18	Anaemias	0.76
C7c	Whooping Cough	0.08	C19	Psychoneuroses and Psychoses	1.98
C7d	Measles	0.17			
C7e	Mumps	0.32	C20	Vascular Lesions Affecting Central Nervous System	1.77
C 8	Typhus and Other Rickettsial Diseases	-	C21	Diseases of Eye	1.51
C 9	Malaria	0.01	C22	Disease of Ear and Mastoid Process	2.76
C10	Diseases Due to Helminths	0.06			
C11	All Other Diseases Classified as Infective and Parasitic	3.14	C23	Rheumatic Fever	0.99
			C24	Chronic Rheumatic Heart Disease	0.47

(a) Classified according to "International Statistical Classification of Diseases, Injuries, and Causes of Death", 1948 Vol. 1, pp. 362-364.

Table 2. (Cont'd) NUMBER OF DISCHARGED CASES PER THOUSAND COVERED PERSONS BY PRIMARY DIAGNOSIS (a), EXCLUDING NEW-BORN, S.H.S.P., 1954.

List No.(a)	Primary Diagnosis	Rate per 1,000 Covered Person	List No.(a)	Primary Diagnosis	Rate per 1,000 Covered Person
C25	Arteriosclerotic and Degenerative heart Disease	4.71	C41	Nephritis and Nephrosis	0.76
C26	Hypertensive Disease	2.14	C42	Diseases of Genital Organs	8.94
C27	Diseases of Veins	3.28			
C28	Acute Nasopharyngitis (Common Cold)	0.27	C43	Deliveries, Complications of Pregnancy, Childbirth and the Puerperium	38.27
C29	Acute Pharyngitis and Tonsillitis and Hypertrophy of Tonsils and Adenoids	15.25	C44	Boil, Abscess, Cellulitis and Other Skin Infections	2.33
C30	Influenza	4.50	C45	Other Diseases of Skin	2.34
C31	Pneumonia	8.85	C46	Arthritis and Rheumatism, except Rheumatic Fever	4.06
C32	Bronchitis	4.82	C47	Diseases of Bones and Other Organs of Movement	2.90
C33	Silicosis and Occupational Pulmonary Fibrosis	-	C48	Congenital Malformations and Diseases Peculiar to Early Infancy	1.80
C34	All Other Respiratory Diseases	5.79	C49	Other Specified and Ill-Defined Diseases	17.20
C35	Diseases of Stomach and Duodenum, except Cancer	4.32	C50	Accidents, Poisonings, and Violence	16.24
C36	Appendicitis	5.62		Not Stated	1.00
C37	Hernia of Abdominal Cavity	2.79			
C38	Diarrhoea and Enteritis	4.11			
C39	Diseases of Gallbladder and Bile Ducts	4.89			
C40	Other Diseases of Digestive System	7.18		All Causes	203.80

(a) Classified according to "International Statistical Classification of Diseases, Injuries, and Causes of Death", 1948 Vol. 1, pp. 362-364.

Source: Annual Report of the Saskatchewan Hospital Services Plan 1954.
Regina: Dept. of Public Health, 1955, Table B6, pp. 48-50.

It may be of interest to examine some of those hospitalized cases which required surgical operations a little more closely than was possible in the above breakdown by diagnosis. All those operations which occurred with a frequency of at least one per thousand covered persons have

been shown in Table 3 in order of frequency, along with the rate of each operation per thousand discharged cases.

Tonsillectomies and adenoidectomies were the most frequent operations performed in Saskatchewan hospitals, occurring at a rate of 12.2 per thousand covered persons, or more than twice the rates for appendectomies and D. & C's, which ranked second and third in order of frequency.⁽¹⁾

Table 3. RATES OF SURGICAL OPERATIONS IN HOSPITAL PER THOUSAND COVERED PERSONS AND PER THOUSAND DISCHARGED CASES, FOURTEEN MOST FREQUENT OPERATIONS, S.H.S.P., 1954

Operation	Rate per 1,000 Covered Persons	Rate per 1,000 Discharged Cases
Tonsillectomy,		
Adenoidectomy	12.2	59.9
Appendectomy	5.0	24.7
Dilatation and Curettage	4.9 (a)	11.5
Tooth Extraction	3.1	15.0
Cystoscopy	2.6	12.7
Herniotomy	2.5	12.3
Hysterectomy	2.3 (a)	5.3
Reduction of Fracture	1.9	9.5
Prostatectomy (c)	1.9 (b)	4.9
Cholecystectomy	1.8	8.8
Circumcision	1.2 (b)	3.1
Local Excision of Skin Area	1.1	5.5
Suture of Wound Injury	1.0	5.1
Haemorrhoidectomy	1.0	4.9

(a) Rates based on 390,532 female beneficiaries.

(b) " " " 419,714 male beneficiaries.

(c) Including transurethral, suprapubic, retropubic, and perineal.

Source: Annual Report of the Saskatchewan Hospital Services Plan, 1954, (Regina: Dept. of Public Health, 1955), Appendix B, Table B7.

(1) For a more detailed discussion of utilization experience under the Saskatchewan program, see G.W. Myers, "Hospitalization Experience of a Government Hospital Care Insurance Plan", Parts I and II, Canadian Journal of Public Health, Vol. 45, 1954, pp. 372-380 and 420-429.

It has frequently been claimed that the volume of hospital care supplied to residents of rural communities and small towns and villages is proportionately much smaller than that obtained by people who live in cities, largely because of differences in incomes among residents of these two types of community, or their ability to purchase hospital insurance. In Saskatchewan, however, actual experience indicates that people in the smaller urban centres were hospitalized more frequently than any others. Cities had the lowest rate, with rural areas somewhat below towns and villages. On the other hand, average length of stay was highest in cities, and slightly higher in rural areas than in the smaller urban centres, with the result that variations in the rate of days of care were not particularly striking. These relationships are shown in Table 4, which reveals that cities experienced a discharge rate of 170 per thousand persons covered as compared with a rate of 221 in villages, whereas the average length of stay was 13.3 days per case in cities and only 10.3 in villages. These differences have been largely explained⁽¹⁾ in terms of the higher fertility rates in rural areas, the greater proximity of patient, doctor, and hospital and therefore the availability of early treatment and home care in urban centres, and the greater coverage of urban occupations under the Workmen's Compensation Act and so on.

(1) G.W. Myers, "Hospitalization Among Residents of Urban and Rural Communities", Canadian Journal of Public Health, Vol. 44, 1953, pp. 43-50.

Table 4. GENERAL HOSPITAL UTILIZATION RATES AND AVERAGE LENGTH OF STAY, BY PLACE OF RESIDENCE, 1951

Residence	Discharged Cases per 1,000 Persons Covered		Average Length of Stay per Case		Hospital Days per 1,000 Persons Covered	
	Crude	Age-Sex Adjusted(a)	Crude	Age-Sex Adjusted(a)	Crude	Age-Sex Adjusted(a)
Cities (b)	177	170	13.3	13.3	2,357	2,253
Towns (c)	223	211	11.2	10.4	2,502	2,193
Villages (d)	232	221	11.2	10.3	2,590	2,276
Rural Areas (e)	197	206	10.1	10.5	1,996	2,156
All Areas	199	-	11.1	-	2,201	-

- (a) After allowance for the varying age and sex distribution of the population in the four types of community.
- (b) Population of 5,000 or more persons.
- (c) " " 500 to 5,000 persons.
- (d) " " less than 500 persons.
- (e) Organized or unorganized territory surrounding incorporated municipalities, with populations ranging from about 500 to 2,000 persons.

Source: G.W. Myers, "Hospitalization Among Residents of Urban and Rural Communities" Canadian Journal of Public Health, Vol. 44, 1953, Table IV, p. 47.

FINANCES

SHSP is financed from the Saskatchewan Hospitalization Fund established under the 1946 Hospitalization Act. All payments for hospital services as well as the costs of administration, including costs of registration and tax collection, are met from the Fund. Revenues are derived from a capitation or "head" tax, with a family maximum, and from general revenues of the province, including since April 1950, a one-third share of the proceeds of a three per cent sales tax.

HOSPITALIZATION TAX

The annual hospitalization tax is payable by or on behalf of every resident of Saskatchewan covered by SHSP.

The tax rate for 1947 and 1948 was \$5 per person with a maximum of \$30 for a family consisting of the father, mother and dependent children under 21 years of age. In 1949, because of rising costs, the tax rate was raised to \$10 for self-supporting persons over the age of 21 years; at the same time, physically or mentally incapacitated dependent children over 21 years were included under the maximum family tax. In 1950 the \$10 tax rate was extended to all persons who had reached the provincial voting age of 18 years. Minors between 18 and 21 years attending an educational institution or nursing school, and incapacitated children over 18 years, were taxed at the adult rate, but their tax was included in the \$30 family maximum. The tax for dependents under 18 years has remained at \$5, but the rate for single persons was increased to \$15 and the family maximum to \$40 in 1954.

The tax is payable in advance, but may be paid in two instalments if it amounts to more than \$20.⁽¹⁾ It is collected by municipal authorities, except in the cities of Regina and Moose Jaw, and in unorganized areas.⁽²⁾ Before benefits can be obtained, not only the required amount of tax for the current period, but also any tax arrears from the preceding five years must be paid.⁽³⁾

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- (1) At least \$20 must be paid in the first instalment.
(2) In Regina and Moose Jaw, and in unorganized areas agencies of the provincial government collect the tax.
(3) Except where the Board of Revenue Commissioners grants approval to make such settlement by instalments.

Personal tax revenues have increased from \$4.85 per capita in 1947 to \$10.86 in 1954, as shown in Table 5. Over this period they have averaged about 46 per cent of total revenues, although in 1949 they accounted for almost 55 per cent of the total, whereas in 1953 they provided only 38 per cent, the remainder consisting of revenues from the provincial treasury.⁽¹⁾ The increase in per capita tax revenues from \$7.75 in 1953, to \$10.86 in 1954, was of course due to the increase in tax rates previously mentioned.

Table 5. TOTAL AND PER CAPITA AMOUNT AND PERCENTAGE DISTRIBUTION OF REVENUES, BY SOURCE, S.H.S.P., 1947 TO 1954

Year	Source of Revenue					
	Hospitalization Tax and Miscellaneous Revenue (a)			Provincial Revenues (b)		
	Amount	Per Capita	Per Cent	Amount	Per Capita	Per Cent
	\$	\$		\$	\$	
1947	\$3,789,059	4.85	50.1	\$3,771,704	4.83	49.9
1948	3,788,515	4.88	41.2	5,416,378	6.97	58.8
1949	5,835,962	7.62	54.5	4,877,015	6.36	45.5
1950	6,015,905	7.85	49.1	6,228,260	8.12	50.9
1951	6,128,402	7.86	43.7	7,882,510	10.11	56.3
1952	6,162,031	7.83	40.9	8,920,791	11.34	59.1
1953	6,234,232	7.75	37.9	10,196,748	12.68	62.1
1954	8,798,264	10.86	51.0	8,444,107	10.42	49.0

(a) Includes personal taxes paid by Province on behalf of public assistance recipients as follows:

1947 - \$130,930; 1948 - \$159,000; 1949 - \$276,645; 1950 - \$275,135; 1951 - \$283,365; 1952 - \$335,797; 1953 - \$364,909; 1954 - \$529,356.

(b) Includes one-third of the proceeds of a sales tax levied under the Education and Hospitalization Tax Act, and other general revenues.

Source: Annual Report of the Saskatchewan Hospital Services Plan, 1954, Tables XXIII and XXVIII.

(1) Unlike the British Columbia and Alberta programs, no municipal grants are made to SHSP.

COSTS OF THE PROGRAM

The total costs of hospitalization have risen each year since the commencement of the program in 1947, amounting to \$16.5 million in 1954. It can be seen from Table 6 that the annual increase in payments to hospitals amounted to \$1.5 - \$1.7 million over the first five years. By 1954, however, the annual increase had fallen to \$700,000. Such increases have been the result of both a greater volume of care and a rise in the average rate paid to hospitals for each patient day. While the increase in hospitalization costs in 1948 could be attributed about equally to each of these factors, for 1949 and 1950 the increase in average amounts per patient day represented roughly 60 per cent of the total increase in expenditures, and the cost of the increase in days of care the remainder. In 1951, however, an increase of over \$1.00 in average per diem costs accounted almost entirely for the increase in expenditures over 1950. Days of care increased only very slightly - from 1,714,071 in 1950 to 1,721,629 in 1951. With a steady decline in days of care to 1,657,274 in 1954, increased expenditures in 1952, 1953 and 1954 are entirely attributable to increases (of 72, 84, and 58 cents respectively) in average per diem costs. Over the eight-year period, the average cost to S.H.S.P. per patient day⁽¹⁾ in Saskatchewan institutions which furnish over 97 per cent of care received by beneficiaries, has

(1) Excluding newborns.

risen steadily from \$4.69 in 1947 to \$9.82 in 1954. For out-of-province care the average cost per patient day⁽¹⁾ rose from \$3.88 in 1947 to \$7.34 in 1954, mainly as a result of changes in the schedule of benefits.

Table 6. TOTAL AND PER CAPITA AMOUNT AND PERCENTAGE DISTRIBUTION OF EXPENDITURES, BY TYPE OF EXPENDITURE, S.H.S.P., 1947 TO 1954.

Year	Total Expenditure			Type of Expenditure					
				Hospitalization Expenses(a)			Administration Expense		
	Amount	Per Capita	Per Cent	Amount	Per Capita	Per Cent	Amount	Per Capita	Per Cent
1947	\$ 7,560,763	\$ 9.68	100.0	\$ 6,963,258	\$ 8.92	92.1	\$ 597,505	\$ 0.76	7.9
1948	9,204,893	11.85	100.0	8,632,778	11.11	93.8	572,115	0.74	6.2
1949	10,712,977	13.98	100.0	10,190,211	13.30	95.1	522,766	0.68	5.0
1950	12,244,165	15.97	100.0	11,708,786	15.27	95.6	535,379	0.70	4.4
1951	14,010,912	17.97	100.0	13,430,802	17.22	95.9	580,110	0.75	4.1
1952	15,082,822	19.18	100.0	14,482,027	18.42	96.0	600,795	0.76	4.0
1953	16,430,980	20.44	100.0	15,826,998	19.69	96.3	603,982	0.75	3.7
1954(b)	17,242,371	21.28	100.0	16,547,768	20.42	96.0	694,603	0.86	4.0

(a) Includes expenses incurred for cases in hospital at year end.

(b) May be increased by retroactive hospital rate changes.

Source: Annual Report of the Saskatchewan Hospital Services Plan, 1954, (Regina: Dept. of Public Health, 1955), Table XXIII, p. 26.

Increased costs can also be expressed in terms of average costs per case and per capita. In 1947 the average cost per case (adults and children) in Saskatchewan institutions was \$46.66, but by 1954 had climbed steadily to \$98.50. Similarly, as shown in Table 6, the average per capita costs of hospital care rose from \$8.92 in 1947 to \$20.42 in 1954, an increase of nearly 130 per cent.

(1) Excluding newborns.

With increased payments to hospitals, there has been a relative reduction in administration expenses over eight years of operation, such costs representing 4.0 per cent of total expenditures in 1954, compared with 7.9 per cent in 1947. A large part of the relative reduction has been due to the employment of a smaller administrative staff; the average number employed dropped from 181 in 1947 to 121 in 1954. As mentioned, the plan utilizes the municipal authorities as tax agencies of the provincial government with respect to the collection of insurance premiums. For this service the municipalities are paid a sum equalling 3 per cent on the first \$100,000 collected and $2\frac{1}{2}$ per cent on the remainder. Following the increase in tax rates, the costs of administration jumped from 75 cents per capita in 1953 to 86 cents in 1954, largely due to increased commissions on tax collections which rose to one-third of total administration costs instead of one-quarter as previously.

Considering the size of hospital bills met by SHSP on behalf of beneficiaries, it is of interest to note that of the 160,980 cases hospitalized in Saskatchewan institutions in 1954, 44 per cent had less than \$50 each paid out to hospitals by the Plan on their behalf, while 77 per cent cost the Plan less than \$100 per case for their hospitalization, as shown in Table 7.

Table 7. NUMBER AND PERCENTAGE AND CUMULATIVE PERCENTAGE DISTRIBUTION OF HOSPITALIZED CASES^(a) IN SASKATCHEWAN INSTITUTIONS, BY EXPENDITURE PER CASE, S.H.S.P., 1954

Expenditure per Case	Number of Discharged Cases	Per Cent of Cases	Cumulative Per Cent of Cases
\$ 0 to 19	26,068	16.2	16.2
20 to 49	45,197	28.1	44.3
50 to 99	52,350	32.5	76.8
100 to 199	23,584	14.7	91.5
200 to 499	10,691	6.6	98.1
500 and over	3,090	1.9	100.0
Total	160,980	100.0	100.0

(a) Excluding newborns.

Source: Annual Report of the Saskatchewan Hospital Services Plan, 1954, (Regina: Dept. of Public Health, 1955), Appendix B, Table B9.

METHOD OF PAYMENT TO HOSPITALS

At the commencement of the scheme a so-called "point system" was adopted whereby Saskatchewan hospitals were paid a per diem rate, on a diminishing scale in accordance with the number of days of care provided. In the calculation of this per diem rate the hospital's essential facilities and services were given a point rating and the total points then calculated in monetary terms. After a year's trial the point system was abandoned as the rates of payment often required supplementary grants to meet actual operating cost.

This system was then replaced by a system of inclusive per diem rates which represented the estimated costs of operation. In 1951, however, a refinement of the method of paying inclusive per diem rates was introduced (for Saskatchewan public general hospitals only), in order to provide an incentive for efficient operation. An average per diem rate, based on estimated occupancy and operating costs (less estimated revenues from sources other than SHSP) is now determined annually through uniform accounting methods. The larger proportion of this per diem rate represents fixed expenditures, such as salaries, fuel and depreciation, which do not vary significantly with occupancy. On the other hand, the hospital's variable expenses, such as food, laundry and drugs which are directly related to occupancy, can be determined and hospitals assigned a variable day rate (from \$1.25 to \$1.75) depending on the rated bed capacity of the hospital. Lump-sum payments are then made semi-monthly, representing slightly more than the estimated fixed per diem costs, while additional sums, depending on actual occupancy, representing slightly less than the variable day rate, are paid to the hospitals when the accounts of their patients are submitted to the Plan. At the end of the year, retroactive rate increases are made by the Plan in certain cases where deficits have been incurred.

The effect of dividing the average per diem cost of operation into two parts is to provide a bonus to hospitals

which have experienced an annual volume of days of care less than their estimated volume, since such hospitals have received a greater proportion of their average per diem costs in terms of their estimated, rather than their actual level of occupancy. The financial incentive to overcrowd hospitals has thus been eliminated.

ADMINISTRATION

The hospital insurance program is administered by the Saskatchewan Hospital Services Plan, a unit of the Medical and Hospital Services Branch under the Deputy Minister of Public Health. The Plan's Executive Director is responsible for the direction of six Divisions - Registration and Tax Collection, Hospitalization, Accounting, Mechanical Tabulation, Office Manager's and Field Services - with an average staff of 121 persons (1954). Briefly, the Plan is responsible for managing the Hospitalization Fund, maintaining records of contributions, and finally paying hospitals for services rendered to eligible beneficiaries. A special Rate Board reviews the hospital budgets and approves the per diem rates to be paid.

As mentioned, the collection machinery of the program is decentralized; the local authorities are responsible for registration and tax collection, with the Plan's Field Division providing liaison and assistance to local collection officials in matters of tax enforcement. All other administrative operations are centralized. The ownership and operation of hospitals, however, remains a local or private responsibility.

CHAPTER III

PUBLIC HOSPITAL AND MEDICAL CARE PLAN

NEWFOUNDLAND COTTAGE HOSPITAL PLAN

The Newfoundland cottage hospital scheme, the first government-sponsored prepaid medical and hospital care plan in British North America, was introduced in Newfoundland in the year 1934.

ORGANIZATION

The cottage hospital system⁽¹⁾ consists of eighteen small cottage hospitals and seven nursing stations with a complement of 503 beds (approximately 3 beds per thousand covered population) and 113 bassinets (December 31, 1954), operated by the Newfoundland Department of Health. Each cottage hospital services an area known as a "cottage hospital district" which may be subdivided into a "hospital medical practice district", "medical practice districts" and, in some cases, "nursing districts". A number of medical practice districts and nursing districts are located in isolated regions outside the boundaries of any cottage hospital area.

Each cottage hospital is supervised by a medical health officer who is generally responsible for the provision of hospital services and public health services throughout the cottage hospital district. In addition, he provides

(1) The cottage hospital plan is designed to provide service in selected regions and does not cover some major population centres, such as St. John's, Corner Brook or Grand Falls.

both domiciliary medical care services in the hospital medical practice district which immediately surrounds the hospital, and emergency medical treatment in other parts of the cottage hospital area. In 1954, twenty-seven physicians were located in the eighteen cottage hospitals; nine hospitals had both a medical health officer and another resident medical officer.

Some thirteen physicians residing in parts of a cottage hospital subscription area beyond the "hospital medical practice district" provide prepaid medical services to residents of so-called "medical practice districts". In other isolated regions of a cottage hospital area where there is no resident doctor, the district nursing service brings a degree of medical care to the inhabitants. Nursing care is also provided on a prepayment basis in some areas outside cottage hospital districts where there is no resident doctor. Finally eighteen physicians in private, fee-for-service practice and located in medical practice districts outside of cottage hospital subscription areas, provide general medical services to indigents⁽¹⁾ for a yearly stipend and also fulfil certain public health functions for which they are remunerated by the province on a fee basis.

(1) Indigent persons living in St. John's who require in-patient or out-patient hospital care receive certification of inability to meet the costs from the Welfare Department. Treatment services are provided at the St. John's General Hospital or at "public health clinics", both operated by the Department of Health.

A secretary appointed for each cottage hospital is concerned with the business management of the hospital and the collection of subscription fees in his cottage hospital area.

COVERAGE

At December 1954, about 154,000 persons⁽¹⁾ (43,600 subscribers and 110,400 dependents) or nearly 40 per cent of the Newfoundland population,⁽²⁾ resided within the eighteen Cottage Hospital subscription areas. Of these, approximately 83 per cent, 128,000 persons (35,000 subscribers and 93,000 dependents), were covered by payment of subscription fees for hospital benefits. Prepaid coverage for domiciliary medical care was available to 75,000 persons resident in hospital medical practice areas and to 39,000 persons in district medical practice areas. Prepaid nursing care was available to 24,000 persons within cottage hospital districts and approximately 3,500 outside cottage hospital districts.

BENEFITS

Benefits include public ward accommodation, all necessary medical and surgical services, drugs and dressings,

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- (1) Included in this subscriber potential were an estimated 6,200 recipients of provincial public assistance, who are encouraged to pay the Cottage Hospital subscription fee, unless payment would impose a hardship. Relief cases (unemployable persons and the employable unemployed) are expected to pay the fee in installments. Old age security beneficiaries are required to pay the subscription fee like any other self-supporting resident of a cottage hospital district.
- (2) Estimated at 398,000 for 1954.

outpatient services, nursing services, and preventive health services. As mentioned, domiciliary medical care is also available in hospital medical practice areas or district medical practice areas.

Referrals to the St. John's General Hospital, a provincially-operated hospital of 446 beds, may be made by the medical health officer for conditions that cannot be treated in a cottage hospital. Treatment at the General Hospital includes ward accommodation, drugs and dressings and necessary medical services.

UTILIZATION

Eighteen hospitals, with a total of 482 beds, admitted 11,024 patients (excluding new-borns) during the calendar year 1954 and provided 100,293 days of care or an average of 9.1 days of stay per patient. Using an estimate of the potentially covered population of 154,000 persons, these hospitals, in aggregate, experienced more than 71 admissions per thousand persons and provided about 651 days of in-patient hospital care per thousand persons.⁽¹⁾ Such rates cannot be considered as representing accurately the total hospital usage by the covered population, however, since they are not based on the actual number of eligible

(1) If the estimated hospital days of cases referred to St. John's General were included, the rate of patient days might increase to approximately 835 days per thousand cottage hospital beneficiaries.

beneficiaries and would also be significantly affected if complete information on patients referred from cottage hospital districts to the St. John's General Hospital could be included.⁽¹⁾ Moreover, all rates are of course affected by the unique geographic characteristics of the province and by the organization of hospital and medical services, particularly the fact that home maternity care is available as a medical benefit.

FINANCES

COTTAGE HOSPITAL FEES

For residents of 15 cottage hospital districts, in-patient and out-patient hospital services and domiciliary medical care are made available at annual subscription rates of \$7.50 for self-supporting single persons and \$15.00 for families. However, persons living in three hospital medical practice areas with a high level of employment and stable wages (Botwood, Channel and Gander) are required to pay \$12.00 and \$24.00 for single persons and families respectively in the first two areas, and \$18.00 and \$36.00 in Gander. In other parts of these three cottage hospital districts the usual rates of \$7.50 and \$15.00 apply. In nursing district areas outside cottage hospital districts, the fees are \$4.50 and \$9.00 for single and family subscribers

(1) If the estimated hospital days of cases referred to St. John's General were included, the rate of patient days might increase to approximately 835 days per thousand cottage hospital beneficiaries.

respectively. Any delinquents requiring services are entitled to full benefits after a waiting period of two weeks, on payment of a late-joining fee, which is equivalent and in addition to the regular subscription rate.

A number of extra charges are imposed on beneficiaries at the time of service. A hospital charge of \$3.50 per day is required for all maternity cases and a fee of \$10.00 for maternity cases attended at home or in hospital, with the exception of Gander and Channel hospital medical practice district where the maternity fee is \$20.00, and Botwood medical practice districts where the maternity fee is \$15.00. Dental extractions are charged at the rate of 50 cents per tooth, except at Botwood, Channel, and Gander where the rate is \$1.00. Private hospital rooms are available to subscribers at the rate of \$4.00 per day, except for maternity patients who are charged at the rate of \$5.00 per day. All medicines and dressings supplied to out-patients must be paid for at the time they are supplied.

HOSPITAL OPERATING COSTS

(1) Cottage Hospitals

While available information does not allow a comprehensive examination of the financial operations of the cottage hospital program, some material is available on the cost of operating 17 of the 18 cottage hospital programs in the fiscal year 1953-54. Total expenditures of these hospitals

of \$1,311,000⁽¹⁾ represented an average expenditure of \$11.80 per patient day, ranging from \$19.17⁽²⁾ in the smallest hospital (at Fogo) with only 6 beds, to \$7.59⁽²⁾ in the largest cottage hospital (Gander) with 94 beds. Total hospital costs, including medical services, per capita, based on a potential population of 151,500, are estimated at \$8.65.

In addition, the cost of 1067 cases referred to St. John's General Hospital is assumed wholly by the province. During 1954, hospitalization of referred cases (involving an estimated 28,500 patient days) cost the province an estimated \$325,000.00, not including fee-for-service payments to physicians providing medical services to referred cottage hospital subscribers. Room and board payments for referred cases in private institutions or homes in St. John's were estimated at \$120,000.

Altogether, then, the total cost of services rendered to beneficiaries under the Cottage Hospital program was approximately \$1,756,000 or nearly \$11.60 per person covered. Subscriber revenues amounted to some \$615,000, leaving a balance of about \$1,141,000 or almost 65 per cent of total expenditures to be borne from general provincial revenues.

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- (1) If payments of \$174,326 to physicians from subscription fees, and from maternity and dental fees and so on are excluded, total expenditures are reduced to \$1,136,717 or \$10.25 per day.
- (2) About \$16.80 and \$6.85 per day respectively when fee payments to physicians are excluded.

(2) St. John's General Hospital

The Province of Newfoundland owns and operates the St. John's General Hospital whose services to referred patients from Cottage Hospital small areas, as mentioned above, are an essential part of the Cottage Hospital Plan. In 1953-54 the net cost of operating this hospital, after deducting revenues from various sources including paying patients, was \$1,284,000. This sum includes, in addition to the costs of in-patient care for Cottage Hospital patients and of services to indigent persons in St. John's, the provincial share of the costs of both in-patient and out-patient services rendered by the hospital.

(3) Other Payments

The province also paid about \$475,000 in 1953-54 to non-government hospitals and to assist in providing health services for indigent persons.

(4) Total Expenditures

Estimated total expenditures in 1953-54⁽¹⁾ of the Cottage Hospital program, the net cost of operating St. John's General Hospital, and other expenditures to provide treatment services in non-governmental institutions amounted to a total of almost \$3.2 million, as follows:

(1) Excluding, of course, the costs of operating T.B. sanatoria and the mental hospital.

Gross Expenditures of seventeen Cottage Hospitals ⁽¹⁾	\$1,311,000
Net cost of St. John's General Hospital ⁽²⁾	1,284,000
Room and board for referred patients to St. John's	120,000
Grants to non-government hospitals and services to Indigents	<u>475,000</u>
Total	\$3,190,000

Of the sum of \$3.2 million, provincial payments amounted to about \$2.6 million; the remainder, \$600,000, was obtained from personal premium revenues and other direct payments by patients in Cottage Hospital areas.

PAYMENTS TO PHYSICIANS

Each cottage hospital doctor is paid a stipend for performing the duties of a medical officer of the hospital and medical health officer of the district. Also, he receives four-ninths, up to a maximum limit, of the fees collected from subscribers in the medical practice area surrounding the cottage hospital, two-thirds of the extra charges for special services such as deliveries and dental extractions, and fee-for-service payments for specified public health duties (e.g. inoculations, venereal disease treatments). For emergency medical care to patients outside a hospital medical practice area, a fee of \$15.00 a day is paid by the province, with the patient assuming any transportation costs.

(1) Excludes one small cottage hospital, additional sums spent on operating dispensaries in certain areas, salaries of District Nurses, and payments to medical officers for certain professional services. Also excludes an estimated \$325,000 for the hospital costs of cases referred to St. John's General Hospital.

(2) Including \$325,000 for cases referred from Cottage Hospitals.

Physicians in district medical practices located within cottage hospital subscription areas are remunerated on the same basis as a cottage hospital physician. Physicians in private practice outside of hospital subscription areas receive stipends for the care of the sick poor, and fee-for-service payments for immunization, venereal disease treatment and so on. It might be mentioned also that the district nurses under the program are paid on a salary basis.

CHAPTER IV

PUBLIC MEDICAL CARE PLANS

THE PREPAID MEDICAL-DENTAL CARE PLAN IN HEALTH REGION NO. I
SWIFT CURRENT, SASKATCHEWAN

A prepaid public medical-dental care program, the only one of its kind in Canada, was inaugurated on July 1, 1946, in Health Region No. I in the southwest corner of Saskatchewan. In 1953, about 47,538 persons⁽¹⁾ (20,400 families) were eligible for prepaid health services, excluding approximately 1,240 beneficiaries of other medical care programs, such as public assistance recipients, Treaty Indians, members of the Armed Forces, and R.C.M.P. With these exceptions, all adults and their dependents under 18 years of age are compulsorily⁽²⁾ covered after three months' residence. About 900 local indigents are covered through payment of contributions on their behalf by the responsible municipality. The average annual enrollment under this program since 1948 is shown in Table 1.

Table 1 - AVERAGE ANNUAL ENROLLMENT, HEALTH REGION NO. I
SWIFT CURRENT, SASKATCHEWAN, 1948-1953

	1948	1949	1950	1951	1952	1953
Average Number of Persons Enrolled	51,454	48,193	48,000	47,640	45,730	47,538

Source: Saskatchewan Dept. of Public Health, Annual Report,
(Regina: Department of Public Health, 1953), p. 27.

(1) Including 31 per cent who were under 15 years of age, 61 per cent between 15 and 65 years, and 8 per cent aged 65 years or over.

(2) See footnote (1) page 94 concerning penalty for failure to register.

BENEFITS

Benefits include comprehensive medical care in home, office and hospital, including major and minor surgery and obstetrical services, rendered by two full time specialists⁽¹⁾ and thirty-one physicians doing general practice,⁽²⁾ including several certified specialists, hospital outpatient laboratory and other diagnostic services, and a special radiological service for referred x-ray examinations. A limited dental care program, with major emphasis on preventive services, is operated for about 9,000 children under 12 years of age by four dentists operating from three permanent dental clinics. Payment for physicians' services outside the Region is limited to 50 per cent of the cost of emergency care, of referrals for diagnosis, and of certain surgical or non-surgical conditions⁽³⁾. The major services excluded are eye refractions, glasses and drugs outside of hospital.

Hospital care, including public ward care, all other hospital services, and most drugs, is provided under the

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- (1) The services of three visiting specialists are also available.
 - (2) Of these 31 physicians, 21 are in 8 group practices, clinics or partnerships, and 10 are general practitioners in solo practice.
 - (3) A list of surgical conditions has been drawn up, and physicians may refer any of these conditions outside the Region without prior authorization. Referrals for other surgical and all non-surgical conditions require prior authorization, which is the responsibility of a committee of three practising physicians appointed by the District Medical Society.

compulsory provincial hospital insurance program. Treatment for cancer, tuberculosis and mental illness is provided under other provincial programs, although physicians' services for cancer or tuberculosis cases prior to their enrollment with the Cancer Clinic or T.B. Sanatorium, and services not covered by the Cancer Clinic or Sanatorium, as well as office or general hospital treatment of mental illnesses, are all paid for by the Region.

VOLUME OF SERVICE

The rate of total medical care services⁽¹⁾ rendered to persons enrolled under the Swift Current program has declined slightly over the four years 1950 to 1953 - by about 6 per cent as follows: 5090 services per thousand beneficiaries in 1950; 4933 services in 1951; 4954 services in 1952; and 4776 services in 1953. The decline in the overall rate in 1951 was due to a sudden drop of 218 per 1000 in the hospital call rate which was offset only slightly by increases in the home call rate and the rate for out-patient diagnostic procedures. With a change in policy late in 1951 regarding the provision of diagnostic procedures in physicians' offices, there was a reduction in such services in 1952 amounting to 527 per 1000; this decline, however, was more than offset by increases of 283 per 1000 in the rate for out-patient department diagnostic

(1) Including physicians' calls, surgery, confinements, laboratory x-ray and other diagnostic services, and all other services provided both in the Region and outside of it.

TABLE 2 - NUMBER AND ANNUAL RATE PER 1,000 BENEFICIARIES OF REGIONAL AND NON-REGIONAL SERVICES, BY TYPE OF SERVICE, SWIFT CURRENT HEALTH REGION, SASKATCHEWAN, 1950 TO 1953

Type of Service	1950					
	In-Region		Out-of-Region		Total	
	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000
Physicians' Calls						
Office	92,167	1920.1	2,350	49.0	94,517	1969.1
Home	15,210	316.9	190	3.9	15,400	320.8
Hospital ^(b)	68,855	1434.5	3,863	80.5	72,718	1515.0
Total Calls	176,232	3671.5	6,403	133.4	182,635	3804.9
Surgical Operations						
Major	2,776	57.8	387	8.0	3,163	65.8
Minor	8,165	170.1	153	3.2	8,318	173.3
Total Operations	10,941	227.9	540	11.2	11,481	239.1
Confinements	1,046	21.8	42	0.9	1,088	22.7
Diagnostic Procedures ^(c)						
Laboratory	24,120	502.5	631	13.1	24,751	515.6
X-Ray	2,366	49.3	255	5.3	2,621	54.6
Other	961	20.0	85	1.8	1,046	21.8
Total Diagnostic Procedures	27,447	571.8	971	20.2	28,418	592.0
Special Services						
Surgical Assistant	585	12.2	81	1.7	666	13.9
Anaesthetist	2,405	50.1	215	4.5	2,620	54.6
Consultant	165	3.4	71	1.5	236	4.9
Interpretation of an X-Ray ^(c)	2,689	56.0	-	-	2,689	56.0
Total Special Services	5,844	121.7	367	7.7	6,211	129.4
All Services	221,510	4614.7	8,323	173.4	229,833	4788.1 ^(a)

See end of Table for footnotes.

TABLE 2 - NUMBER AND ANNUAL RATE PER 1,000 BENEFICIARIES OF REGIONAL AND NON-REGIONAL SERVICES, BY TYPE OF SERVICE, SWIFT CURRENT HEALTH REGION, SASKATCHEWAN, 1950 TO 1953

Type of Service	1951					
	In-Region		Out-of-Region		Total	
	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000
Physicians' Calls						
Office	93,867	1970.4	1,360	28.5	95,227	1998.9
Home	16,228	340.6	131	2.8	16,359	343.4
Hospital (b)	58,193	1221.5	3,609	75.8	61,802	1297.3
Total Calls	168,288	3532.5	5,100	107.1	173,388	3639.6
Surgical Operations						
Major	2,672	56.1	380	8.0	3,052	64.1
Minor	6,069	127.4	202	4.2	6,271	131.6
Total Operations	8,741	183.5	582	12.2	9,323	195.7
Confinements	1,079	22.6	24	0.5	1,103	23.1
Diagnostic Procedures (c)						
Laboratory	21,722	455.9	487	10.2	22,209	466.1
X-Ray	2,934	61.6	201	4.2	3,135	65.8
Other	904	19.0	38	0.8	942	19.8
Total Diagnostic Procedures	25,560	536.5	726	15.2	26,286	551.7
Special Services						
Surgical Assistant	760	15.9	54	1.1	814	17.0
Anaesthetist	2,404	50.5	240	5.0	2,644	55.5
Consultant	133	2.8	182	3.8	315	6.6
Interpretation of an X-Ray (c)	2,890	60.7	2	0.1	2,892	60.8
Total Special Services	6,187	129.9	478	10.0	6,665	139.9
All Services	209,855	4405.0	6,910	145.0	216,765	4550.0 (a)

See end of Table for footnotes.

TABLE 2 - NUMBER AND ANNUAL RATE PER 1,000 BENEFICIARIES OF REGIONAL AND NON-REGIONAL SERVICES, BY TYPE OF SERVICE, SWIFT CURRENT HEALTH REGION, SASKATCHEWAN, 1950 TO 1953

Type of Service	1952					
	In-Region		Out-of-Region		Total	
	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000
Physicians' Calls						
Office	100,024	2,187.3	1,399	30.6	101,423	2,217.9
Home	18,223	398.5	183	4.0	18,406	402.5
Hospital ^(b)	56,669	1,239.2	3,291	72.0	59,960	1,311.2
Total Calls	174,916	3,825.0	4,873	106.6	179,789	3,931.6
Surgical Operations						
Major	2,305	50.4	442	9.7	2,747	60.1
Minor	7,519	164.4	180	3.9	7,699	168.3
Total Operations	9,824	214.8	622	13.6	10,446	228.4
Confinements	1,176	25.7	14	0.3	1,190	26.0
Diagnostic Procedures ^(c)						
Laboratory	192	4.2	546	11.9	738	16.1
X-Ray	62	1.4	258	5.6	320	7.0
Other	34	0.7	53	1.2	87	1.9
Total Diagnostic Procedures	288	6.3	857	18.7	1,145	25.0
Special Services						
Surgical Assistant	697	15.2	59	1.3	756	16.5
Anaesthetist	2,108	46.1	217	4.8	2,325	50.9
Consultant	205	4.5	23	0.5	228	5.0
Interpretation of an X-Ray ^(c)	185	4.0	5	0.1	190	4.1
Total Special Services	3,195	69.8	304	6.7	3,499	76.5
All Services	189,399	4,141.6	6,670	145.9	196,069	4,287.5 ^(a)

See end of Table for footnotes.

TABLE 2 - NUMBER AND ANNUAL RATE PER 1,000 BENEFICIARIES OF REGIONAL AND NON-REGIONAL SERVICES, BY TYPE OF SERVICE, SWIFT CURRENT HEALTH REGION, SASKATCHEWAN, 1950 TO 1953

Type of Service	1953					
	In-Region		Out-of-Region		Total	
	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000	No. of Services	Annual Rate Per 1,000
Physicians' Calls						
Office	101,520	2,135.6	1,403	29.5	102,923	2,165.1
Home	7,525	158.3	179	3.8	7,704	162.1
Hospital (b)	59,851	1,259.0	4,288	90.2	64,139	1,349.2
Total Calls	168,896	3,552.9	5,870	123.5	174,766	3,676.4
Surgical Operations						
Major	2,936	61.8	547	11.5	3,483	73.3
Minor	7,855	165.2	135	2.8	7,990	168.0
Total Operations	10,791	227.0	682	14.3	11,473	241.3
Confinements	1,269	26.7	12	0.3	1,281	27.0
Diagnostic Procedures (c)						
Laboratory	(c)	(c)	426	9.0	426	9.0
X-Ray	(c)	(c)	277	5.8	277	5.8
Other	(c)	(c)	58	1.2	58	1.2
Total Diagnostic Procedures	(c)	(c)	761	16.0	761	16.0
Special Services						
Surgical Assistant	767	16.1	77	1.6	844	17.7
Anaesthetist	2,622	55.2	195	4.1	2,817	59.3
Consultant	211	4.4	15	0.3	226	4.7
Interpretation of an X-Ray (c)	241	5.1	5	0.1	246	5.2
Total Special Services	3,841	80.8	292	6.1	4,133	86.9
All Services	184,797	3,887.4	7,617	160.2	192,414	4,047.6 (a)

(a) If laboratory and other diagnostic procedures performed in hospital out-patient departments were added to these figures, the total rates for all services would become 5,090.4, 4,933.4, 4,953.9 and 4,776.2 per thousand in 1950, 1951, 1952 and 1953 respectively.

(b) Excludes calls to operative cases.

(c) Payments to physicians for diagnostic procedures performed in their offices were discontinued late in 1951.

Sources: Saskatchewan Department of Public Health, Annual Reports, (Regina: 1951-1953).
Saskatchewan Department of Public Health, "Swift Current Medical Care Program, Health Region No. I, Statistical Tables", 1952, 1953. (Mimeographed)

procedures, and 219 per 1000 in the office call rate, as well as smaller increases in the home and hospital call rates. As a result, the overall rate for 1952 increased slightly. The lowest rate of 4776 services in 1953 was very largely due to a sharp reduction in the rate of home calls, from 402 per thousand in 1952 to 162 in 1953 or from 398 to 158 in-region calls. It is believed that this rapid decline in the home call rate was due to the fact that, beginning in January 1953, a direct charge could be made on a patient by a physician, amounting to \$2.00 for night, Sunday, and holiday calls at home, and \$1.50 for other home calls.⁽¹⁾

Out-of Region services have represented less than 4 per cent of all services provided under the program, as is evident from an examination of Table 2, which presents the number and rate of services rendered for all of the items of medical care made available to Swift Current beneficiaries.⁽²⁾ It is perhaps more useful then to confine comment on utilization rates to the services rendered in the Region only.

Physicians' call and surgery rates within the Region have been summarized in Table 3. It will be noted here that in general, both office and home call rates increased over the period 1950 through 1952 while the rates for

(1) See page 98.

(2) Excluding diagnostic procedures and x-rays provided through outpatient departments of Regional hospitals. See footnote (a) Table 2, and Table 4.

hospital calls and major surgery tended to decline. As will be observed, such increases actually predate 1950. It is particularly interesting to note the very rapid decline in the rate of home calls from 398 per thousand in 1952 to 158 in 1953, due in some measure to the introduction of deterrent charges on home calls, as mentioned above. Another trend which is of special interest is the fact that after a peak year in 1949, major surgical operations began a slow decline, but in 1953 returned to a rate of 62 operations per thousand beneficiaries.(1)

Table 3 - ANNUAL RATES PER THOUSAND BENEFICIARIES OF REGIONAL PHYSICIANS' CALLS AND SURGICAL OPERATIONS, 1948-53

Item	1948	1949	1950	1951	1952	1953
Physicians' Calls						
Office	1626	2026	1920	1970	2187	2136
Home	190	291	317	341	398	158
Hospital	928	1308	1435	1222	1239	1259
Total Calls	2744	3625	3672	3533	3824	3553
Surgery						
Major	48	64	58	56	50	62
Minor	Not Available	Not Available	170	127	164	165
Total Surgery			228	183	214	227

Source: Saskatchewan Dept. of Public Health, "Swift Current Medical Care Program, Health Region No. I. Statistical Tables", 1951, 1952, 1953. (Mimeographed).
Saskatchewan Health Services Planning Commission, "Statistical Tables relating to physicians' calls, special services, surgical operations, and costs distribution in the Medical Care Program of Health Region No. I, Swift Current, Saskatchewan, 1948." (Mimeographed).

(1) Out of Region major surgery also increased slightly, from a rate of 9.7 operations in 1952 to 11.5 in 1953.

Having in mind the increasing importance of diagnostic and laboratory services in modern medical practice, it is useful to note the annual rates of such services from 1949 to 1953 as shown in Table 4. The five years' experience actually shows these rates to have declined by about 20 per cent. The low rates of diagnostic and x-ray procedures performed in physicians' offices in 1952 and 1953 and conversely, the increased rates of such services rendered through outpatient departments of hospitals, were the result of a change in policy, late in 1951, whereby physicians were no longer remunerated for most diagnostic procedures performed in their own offices. Alternative arrangements were made with the outpatient departments of hospitals to accept referred cases for diagnostic services and be reimbursed by the Plan.

Table 4 - ANNUAL RATES PER THOUSAND BENEFICIARIES,
DIAGNOSTIC PROCEDURES IN PHYSICIANS' OFFICES
AND OUT-PATIENT DEPARTMENTS 1949 TO 1953

	1949	1950	1951	1952	1953
Physicians' Offices	713.7	592.0	551.7	25.0 ^(a)	16.0 ^(a)
Out-Patient Departments	231.4	302.3	383.4	666.4	728.6
Total	944.1	894.3	935.1	691.4	744.6

(a) Mostly non-regional physicians.

Source: Swift Current Medical Care Program, Health Region No. I, Saskatchewan, unpublished data.

FINANCES

The program is financed by a combination of property and personal taxes in the municipalities, supplemented by provincial government grants amounting in 1953 to about thirteen per cent of the total annual budget.

Personal tax rates in 1954 were: \$18.00 for a single person, \$29.00 for a family of two, \$37.00 for a family of three, and \$44.00 for a family of four or more.⁽¹⁾ This tax is paid by all self-supporting persons who have resided in the Region for more than three months. Persons over 18 years, dependent by reason of physical or mental deficiency, or by reason of attending a nursing school or educational institution if they are under 21 years, are included in the family rate. In 1953, about 64 per cent of the total budget was collected from this source, or \$10.64 per beneficiary.

The property tax rate, based on the last revised assessment, varies from one municipality to another, but amounts to an average of 2.2 mills. About 23 per cent of the 1953 revenues were derived from this tax, which amounted to about \$3.76 per beneficiary. In return for a 3 per cent

(1) Residents also pay the following rates for comprehensive hospital benefits under the provincial hospital insurance plan: \$15 for self-supporting adults over 18 years; \$5 for dependents under 18 years or incapacitated persons over 18 years, or dependents between 18 and 21 years attending educational institutions; a maximum of \$40 is placed on the amount of total family premium.

commission thereon, both personal and property taxes are collected by the local municipalities, which are legally responsible for the tax arrears of those self-supporting persons registered⁽¹⁾ with them for care under the program, as well as for premium payments on behalf of local indigents.

Provincial grants are designed chiefly to assist the dental, radiological, and outpatient services of the Region. In 1953, they included a flat grant of 25 cents per capita for medical care, fifty per cent of the cost of the dental, outpatient and radiology programs up to maxima of \$20,000, \$27,500, and \$7,500 respectively, and seventy-five per cent of the cost of the statistical department. In addition, special grants of \$25,000 each were paid in the years 1951 to 1953, conditional upon the Regional Board showing operating surpluses in each year of at least \$25,000; this grant expired in 1953. Provincial payments represented about 13 per cent of the program's 1953 revenues.

Table 5 indicates the revenues and expenditures of the program in 1953. It is anticipated that expenditures will reach about \$740,000 in 1954.

(1) New residents are required to register with their municipal secretary within 15 days of arrival, on penalty of a \$25 fine.

Table 5 - TOTAL AND PER CAPITA AMOUNT AND PERCENTAGE
DISTRIBUTION OF REVENUES AND EXPENDITURES, BY
SOURCE AND TYPE OF SERVICE, HEALTH REGION NO. I,
SASKATCHEWAN, 1953

Item	Amount	Per Capita	Per Cent
	\$	\$	
Revenues			
Personal Tax	505,656	10.64	64.1
Property Tax	178,711	3.76	22.7
Provincial Grants	100,915	2.12	12.8
Penalty on Arrears	3,609	.07	0.4
Total	788,891	16.59	100.0
Expenditures			
Medical Services	502,400	10.57	63.7
Dental Services	52,826	1.11	6.7
Out-Patient Diagnostic Services	71,817	1.51	9.1
Radiological Services	17,786	.37	2.3
Administration & Statistics	72,251	1.52	9.2
Capital Charges	2,274	.05	.3
Total	719,354	15.13	91.2
Allowance for Uncollected Taxes	15,352	.32	1.9
Surplus	54,185	1.14	6.9

Source: "Financial Statement, 1953", Swift Current Medical
Care Program, Health Region No. I, Saskatchewan.
(Mimeographed)

In per capita terms, medical, dental, out-patient
diagnostic, and radiological services together accounted for
expenditures of \$13.56 per beneficiary in 1953, representing
a gradual increase since 1950 when the corresponding figure
was \$12.54 per capita, as shown in Table 6. Similarly, the
costs of physicians' services alone have increased from

\$10.10 to \$10.57 per capita over this period, while the costs of regional physicians' services, excluding diagnostic procedures, increased by \$1.50, from \$8.21 to \$9.71 per capita, between 1949 and 1953. The highest average expenditure on this item occurred in 1949, when \$10.65 per capita was paid out, including \$1.78 for physicians' services outside Health Region No. I. In 1950, however, a new fee schedule was adopted; the number of referrable conditions was limited, and payment for cases referred outside the Region was reduced from 75 per cent to 50 per cent of the new schedule. In consequence, non-regional costs fell from \$1.78 in 1949 to 78 cents per capita in 1950. Administrative costs also increased between 1950 and 1952, from \$1.17 to \$1.38 per capita, but fell to \$1.28 in 1953. The cost of administration (including commissions on tax collections) and statistics together have amounted to about 10 per cent of total expenditures over this period.

METHOD OF PAYMENT

The method of payment for medical services is based on the fee-for-service principle, using a special Schedule of Fees for Contract Practice. Each year a stated amount has been budgeted for medical care, and this is pro-rated among the doctors in accordance with services rendered. Each doctor submits his bill for services performed (charging 100 per cent of the 1949 Contract Schedule of Fees) to the Health Region office, where it is checked and assessed

Table 6 - PER CAPITA EXPENDITURES ON SELECTED ITEMS OF CARE AND ADMINISTRATION, HEALTH REGION NO. I SASKATCHEWAN, 1949 TO 1953

Item	1949	1950	1951	1952	1953
	\$	\$	\$	\$	\$
Physicians' Services					
In-Region ^(a)	8.87	9.32	9.36	9.54	9.71
Non-Region	1.78	.70	.73	.78	.86
Total Physicians' Service	10.65	10.10	10.09	10.32	10.57
Dental Services	1.06	1.12	1.17	1.28	1.11
Out-Patient Diagnostic Services	.91	1.02	1.04	1.52	1.51
Radiological Services	.30	.30	.34	.37	.37
Total All Services	12.92	12.54	12.64	13.49	13.56
Administration and Collection	1.09	1.17	1.25	1.38	1.28
Statistics	.16	.23	.21	.25	.24
Capital	.08	.14	.20	.10	.05
Total Expenditures	14.25	14.08	14.30	15.22	15.13

(a) If diagnostic procedures were excluded, these figures would be reduced to \$8.21, \$8.76, \$8.77, \$9.52, and \$9.71 respectively.

Source: Saskatchewan Dept. of Public Health, Annual Reports, (Regina: 1951-1953).
Saskatchewan Dept. of Public Health, "Swift Current Medical Care Program, Health Region No. I, Statistical Tables", 1952, 1953. (Mimeographed).

by a Medical Assessor. From 1950 to 1952 monthly payments of 60 per cent of the assessed medical bills were made to each physician. Supplementary payments were made quarterly from what was left over in the pool on a pro-rata basis for all assessed accounts.

This pool, or "ceiling", in 1952 amounted to \$435,000, with provision for a \$4,500 adjustment for every 500 increase or decrease in the enrolled population; an additional \$50,000 was budgeted for out-of-region accounts. The doctors practising in the Region received 68.8 per cent of the value of their fees as rendered in 1950. This proportion fell to 64.3 per cent in 1951, but rose again to 67.9 per cent in 1952.

Two fundamental changes in the methods of paying physicians were introduced in 1953, following negotiations between the profession and the Regional Board. The physicians were guaranteed minimum payments of 75 per cent of the fees set forth in the fee schedule; to implement this, the ceiling was increased to \$460,000. As a result, the regional doctors received payments in 1953 amounting to 78.6 per cent of the assessed value of the claims they submitted. The second change was the requirement, for the first time, that patients pay deterrent charges for in-Region home calls, which, as previously noted in Table 2, had risen from 317 per thousand in 1950 to 399 per thousand in 1952. Charges of \$2 were introduced in January 1953 for night, Sunday, and holiday calls at home, and of \$1.50 for other home calls, and in August charges of \$1 were introduced for office calls and minor surgery. The volume of home calls fell by 60 per cent in 1953, from 399 to 158 per thousand. The office call rate declined from 2187 per thousand to 2136 in the same year;

the latter rate, however, conceals the fact that the office call rate had been increasing rapidly during the first seven months of 1953. Based on seven months' experience, an annual rate of 2396 office calls per thousand would have prevailed in 1953; however, following the introduction of the \$1 deterrent charge in August, the volume of office calls dropped sharply in the last five months, so that an annual rate based on this period would have amounted to only 1771 per thousand. With a decline in the home call rate of 60 per cent between 1952 and 1953, and in the office call rate of 26 per cent between the first seven and the last five months of 1953, it would appear that the new deterrent charges have had considerable influence on the volume of services rendered under the Swift Current program.

With the evident success of this measure, further deterrents were introduced in 1954, when physicians were permitted to charge patients \$3 for night, Sunday, and holiday calls, and \$2 for other home calls, with no change in the \$1 charge for office calls and minor surgery. Physicians are free to collect these deterrent fees or not, as they see fit, but such sums are automatically deducted from the accounts they render to the Plan. Also in 1954, physicians were guaranteed minimum payments of 80 per cent of their fees, with a maximum percentage of 90.

Considering the other services available under the plan, it should also be noted that four dentists and a

full-time radiologist are employed on a salary basis, while hospitals are paid on a fee schedule (usually 50 per cent of the practitioner's schedule) for diagnostic services provided through out-patient departments.

ADMINISTRATION

Health Region No. I is a corporate body, enjoying powers similar to those of a municipal corporation. It arranges its own taxation, and enters into contracts with physicians and with the District Medical Society, subject to the approval of the Minister of Public Health. A Regional Health Council, consisting of one representative from each of the 76 municipalities, meets annually to elect a Regional Board of twelve, which is responsible for carrying out general policy determined by the Council. Finally, the Minister must approve all Regional budgets.

MUNICIPAL DOCTOR PLANS IN SASKATCHEWAN

A program designed to attract doctors to rural areas was adopted in Saskatchewan in 1914, whereby a village or rural municipality would enter into a contract with a physician, guaranteeing him an assured income in return for the medical care he agreed to provide for all residents of the municipality. Such "municipal doctor plans" have long been in operation in the province, although their number has been decreasing in the last few years.

In 1953, 95 rural municipalities, and 62 towns and villages had contracts with physicians under which medical care was provided to about 172,000 persons, or about one-fifth of the provincial population. By the end of 1954, this figure had been reduced to 168,000 persons. Although for the most part all residents of these municipalities are entitled to obtain medical care, a few of the plans restrict benefits to ratepayers only.

There is considerable variation from one municipality to another in the scope of the services provided under these schemes. Whereas in 1950 almost three-fifths of the plans made provision for major surgery as well as general practitioner care (that is, home, office and hospital calls, minor surgery and obstetrical care), by 1953 only about one-third of the plans provided for such a comprehensive range of benefits.

The remainder of the schemes provided general practitioner care only. The contracting physician is also expected to provide certain public health services. In a few instances provision is also made for referred specialist services; for example, the Health Services Union (18 communities in the Regina area) have arranged with specialists under contract with Group Medical Services, a non-profit plan in Regina, to provide specialist care on referral with the specialist fees paid at 100 per cent of the Contract Fee Schedule in use in Saskatchewan. Although the benefits provided under these plans are, for the most part, free to all residents, some plans allow the doctor to charge deterrent fees of \$1.00 for home calls after 6 p.m., or on Sundays, and for office calls at inconvenient hours. No statistics are available from which to analyze the effect of such restrictions.(1)

These municipal programs may be financed by a property tax, a personal tax, or a combination of these two, assisted by provincial grants. Although about three-quarters of the rural municipalities met their costs in 1950 through a general property tax, which varied from three to ten mills, in the period since then several municipalities have changed to a personal tax program. The personal tax rates for a family are limited under the Health Services Act to a maximum of \$50 annually, but the usual rates are \$10-\$15 for a single person, \$25 for a couple, and \$5 for each dependent. Indigents who are

(1) But see p. 99 .

the municipality's responsibility have the tax paid for them by the municipality. Transients may receive care upon the payment of a small fee. A semi-annual grant to municipal plans approved by the Minister of Public Health, is made by the provincial Department of Public Health. This grant is calculated on the basis of a flat annual grant of 25 cents per capita, with an equalization grant to compensate for discrepancies due to the varying per capita municipal property assessments. In the fiscal year 1952-53, provincial medical care grants to 112 local areas ranged from 25 cents to \$2.25 per capita and amounted in total to about \$64,000, as compared with grants to 106 communities in 1948-49 totalling \$106,000. The cost of the majority of programs providing basic medical services only, ranged from \$3.00 to \$4.50 per capita in 1950, and from \$3.50 to \$5.00 per capita in 1952. In the majority of the more extensive programs which gave both medical and surgical care, the average cost varied from \$4.50 to \$8.00 per capita in 1950, increasing by 1952 to a range of \$7.00 to \$10.50 per capita.

In order that the municipality may be eligible for the provincial grants, the contract between the municipality and the physician must conform to the standards laid down in a "model contract". This model contract, (1) drawn up by a committee of representatives of the College of Physicians and Surgeons, the Association of Rural Municipalities, and the Department of Public Health, is designed to achieve some

(1) A copy of the model contract is shown in Saskatchewan Health Survey Report, Vol. I, Health Programs and Personnel (Govt. of Saskatchewan: Regina, 1951), Appendix N.

degree of uniformity in the scope of diagnostic, treatment and preventive services, arrangements for holidays and post-graduate study leave, and the efficient handling of disputes. In 1950 about three-quarters of the 173 municipalities under the program had approved contracts.

The municipal council in its contract with the physician, of which there is usually one to a municipality, (1) may agree to pay him on a salary, fee-for-service, or capitation basis, or by a combination of these methods. Operating expenses and office accommodation may be provided. The majority of schemes providing a basic general practitioner service remunerate the physician by the payment of a salary. Surgery or specialist care is usually provided on a fee-for-service basis. It has been roughly estimated that in 1949 municipal contract practice was about one-half of the physician's total practice in most areas.

The procedure for establishing a municipal doctor scheme is specified in the Health Services Act of 1950. The Council of each municipality within a medical care district makes the decision upon petition of 10 per cent or 100 electors, whichever is less, with regard to the formation of a district. The question is then voted upon by the residents and, if it is approved by a majority of the ratepayers, a contract is written

(1) Except where surgical benefits are provided.

with the participating doctor following approval by the Minister. When more than one municipality is included, the scheme is administered by a joint board known as a Municipal Health Services Board. The Department of Public Health supervises the over-all operations of the program through a Supervisor of Municipal Doctor Plans.

MUNICIPAL DOCTOR PLANS IN MANITOBA

The Manitoba Health Services Act of 1945 made provision for the co-ordination and extension of a number of local health services, including the provision of local health units, units for diagnostic laboratory and X-ray services, and the organization of medical and hospital districts. There were fifteen medical care districts established in Manitoba by 1954. Fourteen of these were in operation during the year, providing general medical care to approximately 30,500 persons or about four per cent of the total population of the province.

Persons resident in the districts who pay the tax, or have it paid on their behalf, are eligible for treatment benefits. The benefits provide general practitioner care, including treatment in the office, home, and hospital, minor surgery, (involving procedures with a fee of less than \$20), normal obstetrics, and in certain plans, the removal of tonsils and adenoids. A fee may be charged for services not included in the contract. The physician must also assume the duties of a medical officer of health in the district.

The provincial Department of Health and Public Welfare has formulated for the use of the municipalities a standard contract specifying, in 1955, a minimum salary of \$6,000 and a maximum of \$8,000,⁽¹⁾ and an expense allowance of

(1) Prior to 1955, the minimum salary was \$4,000, rising by annual increments of \$500 up to a maximum of \$7,000. Municipalities are free to pay a salary higher than the minimum.

approximately \$1,500 to \$2,000. In some contracts, physicians are allowed to charge patients additional fees at the time of service. A pension plan is in force to provide a pension of \$1200 annually to a physician at age sixty years; the municipality must contribute \$200 per year to these annuities. A municipality is also required to contribute \$100 towards an accident and sickness insurance policy which the physician must take out, and to provide a month's vacation with pay and a short annual education leave.

The total cost of operating the 14 Municipal Doctor Plans was approximately \$105,000 in 1954. The per capita cost was about \$3.47 for the year. Of the fourteen physicians under contract, eleven were on a salary basis and received from \$4500 to \$7500 a year, and an expense allowance. The remaining three physicians were on individual contracts which had been in effect prior to 1945, but provision was seldom made for pensions and sick benefits on their behalf. The eleven physicians on salary averaged approximately \$6,000 in 1954, exclusive of fees from patients for services not provided under the Plan, such as major surgery, the administration of anaesthetics, and the treatment of venereal diseases and drug or alcoholic addiction.

A municipal corporation (or a number of corporations) may, by by-law, develop a medical care district and arrange for

the provision of medical services, but if the by-law requires the expenditure of any money by the municipality, it must receive the approval of three-fifths of the ratepayers. A plan must be developed and submitted to the Department of Health and Public Welfare for approval. Negotiations with physicians are carried out directly by the municipalities but the contract must be approved by the Department of Health and Public Welfare.

PUBLICATIONS IN THE SOCIAL SECURITY
AND THE GENERAL SERIES

Research Division,
Department of National Health and Welfare

I. SOCIAL SECURITY SERIES

- * Memorandum No. 1. Mothers' Allowances Legislation in Canada. 1st ed. May 1949, 2nd ed. January, 1955, pp.
- * Memorandum No. 2. Old Age Income Security in New Zealand. March 1950. 41 pp.
- * Memorandum No. 3. Old Age Income Security in Australia. March 1950. 31 pp.
- ✓ Memorandum No. 4. Old Age Income Security in Great Britain. March 1950. 84 pp.
- ✓ Memorandum No. 5. Old Age Income Security in the United States. March 1950. 76 pp.
- ✓ Memorandum No. 6. Old Age Income Security in Selected European Countries. (Denmark, France, Sweden, Switzerland). March 1950. 83 pp.
- O Memorandum No. 7. Social Security in Australia.
- * Memorandum No. 8. Health Insurance in New Zealand. October 1950. 88 pp.
- * Memorandum No. 9. Health Insurance in Denmark. (Revised) March 1952. 67 pp.
- * Memorandum No. 10. Health Insurance in Sweden. January 1952. 76 pp.
- * Memorandum No. 11. Health Insurance in Great Britain, 1911-48. March 1952. 163 pp.
- O Memorandum No. 12. Health Insurance in Norway. Est. 60 pp.
- O Memorandum No. 13. Health Insurance in the Netherlands. Est. 65 pp.
- * Memorandum No. 14. Government Expenditures and Related Data on Health and Social Welfare 1947 to 1953. 2nd ed. June 1955. 84 pp.
- * Memorandum No. 15. Selected Public Hospital and Medical Care Plans in Canada. July 1955. 109 pp.

II. GENERAL SERIES

- / Memorandum No. 1. Survey of Dentists in Canada. 2nd ed., January 1949, 45 pp.
- * Memorandum No. 2. Survey of Physicians in Canada. 3rd ed., Sept. 1948, 4th ed., Sept. 1949, 5th ed., June 1951, 6th ed., April 1955, 36 pp.
- * Memorandum No. 3. Survey of Welfare Positions: Report April 1954. 182 pp. and appendices.
- * Memorandum No. 4. Voluntary Medical Care Insurance: A Study of Non-Profit Plans in Canada, April 1954, 208 pp.
- * Memorandum No. 5. A Study of the Functions and Activities of Head Nurses in a General Hospital. May 1954, 140 pp.
- * Memorandum No. 6. Mental Health Services in Canada, July 1954, 207 pp.
- * Memorandum No. 7. Changes and Developments in Child Welfare Services in Canada, 1949-1953. October 1954, 33 pp.
- * Memorandum No. 8. Survey of Welfare Positions, Summary of Report. May 1955. 34 pp.
- * Memorandum No. 9. Voluntary Medical and Hospital Insurance in Canada. August 1955. 61 pp.
- * Memorandum No. 10. Hospitals in Canada. September 1955. pp.
- * Memorandum No. 11. Tuberculosis Services in Canada. July 1955. 65 pp.
- * Memorandum No. 12. Health Care in Canada Expenditures And Sources of Revenue, 1953. August 1955, est. 25 pp.

III. OTHER PUBLICATIONS

Bulletins prepared in collaboration with other Divisions of the Department or other agencies.

- * Survey of Nursing Personnel in Manitoba, October 1952, 59 pp.
- * A Suggested Methodology for Fluoridation Surveys in Canada, July, 1952, 51 pp.

- * Dental Effects of Water Fluoridation, 1954 Report, August 1954, 33 pp.
- ✓ Rehabilitation of Disabled Persons. Background Data for the National Conference on Rehabilitation, Toronto, Feb. 1 - 3, 1951, 135 pp.
- * Social Security Expenditures in Australia, Canada, Great Britain, New Zealand and the United States 1949-50 - A Comparative Study, February, 1954, 42 pp.

Canadian Sickness Survey

- V Special Compilation: No. 1. Family Expenditures for Health Services (National Estimates), May, 1953, 13 pp.
- V Special Compilation: No. 2. Family Expenditures for Health Services by Income Groups (National Estimates), July, 1953, 13 pp.
- V Special Compilation: No. 3. Family Expenditures for Health Services by Expenditure Group (National Estimates), September, 1953, 56 pp.
- V Special Compilation: No. 4. Family Expenditures for Health Services (Regional Estimates), January, 1954, 23 pp.
- V Special Compilation: No. 5. Volume of Sickness (National Estimates), April, 1954, 24 pp.
- V Special Compilation: No. 6. Permanent Physical Disabilities (National Estimates), February, 1955, 15 pp.
- V Special Compilation: No. 7. Incidence and Prevalence of Illness (National Estimates), April, 1955, 20 pp.

* Available on request. ✓ Out of print. 0 In preparation.

V Available from Queen's Printer, 25 cents a copy.

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